

14084

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13976

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Boyd's</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>H.</u> Middle <u>Adams</u> Last				4. DATE OF DEATH <u>Dec. 6</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul. 18, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Addison E. DUFFIN</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Nolan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>022-22-55</u>			
17. INFORMANT <u>Edna Johnson, Sister</u>				Address <u>Boyd's, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia, Bilateral</u> 174 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Metastatic Pulmonary Adenocarcinoma</u> DUE TO (c) <u>Primary Adenocarcinoma Uterus</u> 5 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-10, 1959</u> to <u>12-6, 1960</u> , that (II) (we) last saw the deceased alive on <u>12-5, 1960</u> , and that death occurred on <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edna J. Jackson</u>				22b. DATE SIGNED <u>12-6-60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>202 Market Lane, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>SHIPPED</u>		<u>12/10/60</u>		<u>CHISOLM FUNERAL CHAPEL.,</u>		<u>BOSTON, MASS.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>ROCKVILLE, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 12 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Knecht</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FD 1921

14085

CERTIFICATE OF DEATH

Reg. Dist. No. 13977

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle D Last Alexander		4. DATE OF DEATH Month Dec Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 12 Days 22 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A. 15 yrs	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Son (B.R. Alexander)	
17. INFORMANT Son (B.R. Alexander)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 1955, to 12/22 , 19 60 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. John M Wyman M.D.		780I Norfolk Ave, Bethesda. Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-26-60	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) Front Royal, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Funeral Home, Front Royal, Va.		24a. REC'D BY REGISTRAR DATE DEC 28 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14085

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1910

5. Place of death: Home

6. Cause of death: Heart disease

7. Signature of physician: Dr. J. A. Smith

8. Signature of registrar: W. B. Jones

9. Date of registration: Jan 16, 1910

10. Place of registration: Boston

11. Name of informant: John Doe

12. Address of informant: 123 Main St.

13. Signature of informant: John Doe

14. Date of completion: Jan 16, 1910

15. Place of completion: Boston

16. Name of registrar: W. B. Jones

17. Signature of registrar: W. B. Jones

18. Date of registration: Jan 16, 1910

19. Place of registration: Boston

20. Name of informant: John Doe

21. Address of informant: 123 Main St.

22. Signature of informant: John Doe

23. Date of completion: Jan 16, 1910

24. Place of completion: Boston

25. Name of registrar: W. B. Jones

26. Signature of registrar: W. B. Jones

27. Date of registration: Jan 16, 1910

28. Place of registration: Boston

29. Name of informant: John Doe

30. Address of informant: 123 Main St.

31. Signature of informant: John Doe

32. Date of completion: Jan 16, 1910

33. Place of completion: Boston

34. Name of registrar: W. B. Jones

35. Signature of registrar: W. B. Jones

36. Date of registration: Jan 16, 1910

37. Place of registration: Boston

38. Name of informant: John Doe

39. Address of informant: 123 Main St.

40. Signature of informant: John Doe

41. Date of completion: Jan 16, 1910

42. Place of completion: Boston

43. Name of registrar: W. B. Jones

44. Signature of registrar: W. B. Jones

45. Date of registration: Jan 16, 1910

46. Place of registration: Boston

47. Name of informant: John Doe

48. Address of informant: 123 Main St.

49. Signature of informant: John Doe

50. Date of completion: Jan 16, 1910

51. Place of completion: Boston

52. Name of registrar: W. B. Jones

53. Signature of registrar: W. B. Jones

54. Date of registration: Jan 16, 1910

55. Place of registration: Boston

56. Name of informant: John Doe

57. Address of informant: 123 Main St.

58. Signature of informant: John Doe

59. Date of completion: Jan 16, 1910

60. Place of completion: Boston

61. Name of registrar: W. B. Jones

62. Signature of registrar: W. B. Jones

63. Date of registration: Jan 16, 1910

64. Place of registration: Boston

65. Name of informant: John Doe

66. Address of informant: 123 Main St.

67. Signature of informant: John Doe

68. Date of completion: Jan 16, 1910

69. Place of completion: Boston

70. Name of registrar: W. B. Jones

71. Signature of registrar: W. B. Jones

72. Date of registration: Jan 16, 1910

73. Place of registration: Boston

74. Name of informant: John Doe

75. Address of informant: 123 Main St.

76. Signature of informant: John Doe

77. Date of completion: Jan 16, 1910

78. Place of completion: Boston

79. Name of registrar: W. B. Jones

80. Signature of registrar: W. B. Jones

81. Date of registration: Jan 16, 1910

82. Place of registration: Boston

83. Name of informant: John Doe

84. Address of informant: 123 Main St.

85. Signature of informant: John Doe

86. Date of completion: Jan 16, 1910

87. Place of completion: Boston

88. Name of registrar: W. B. Jones

89. Signature of registrar: W. B. Jones

90. Date of registration: Jan 16, 1910

91. Place of registration: Boston

92. Name of informant: John Doe

93. Address of informant: 123 Main St.

94. Signature of informant: John Doe

95. Date of completion: Jan 16, 1910

96. Place of completion: Boston

97. Name of registrar: W. B. Jones

98. Signature of registrar: W. B. Jones

99. Date of registration: Jan 16, 1910

100. Place of registration: Boston

14072

CERTIFICATE OF DEATH

Reg. Dist. No. 13978

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>U.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Sanatorium</i>		d. STREET ADDRESS <i>39 Franklin St</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLOTTE STEELE ATKINS</i>		4. DATE OF DEATH Month <i>12</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23^d 1886</i>
9. AGE (In years lost birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nevett Steele</i>		14. MOTHER'S MAIDEN NAME <i>Anna Brooke</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Capt Lew M. Atkins U.S.N.</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC HEART DISEASE</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>CEREBRAL SCLEROSIS</i> DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>SENILITY</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>DEC 8</i> , 19 <i>59</i> , to <i>12-11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>12-11</i> , 19 <i>60</i> , and that death occurred at <i>2:15</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry J. London</i> M.D.		ADDRESS (Street, city or town, state) <i>5206 Norwary Dr.</i>	
PHYSICIAN'S NAME (Type) <i>Cherry Chase, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-14-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Naval Academy Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Krasa</i>	
ADDRESS <i>Annapolis Md</i>		DATE <i>DEC 15 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



14019

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13979

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b Since 11/26/60 d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 10,213 McKENNY AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEONARD Middle (NMI) Last AVERY		4. DATE OF DEATH Month DEC. Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31, 1885
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman; Ivy-City Repair Shop-Union Station	11. BIRTHPLACE (State or foreign country) WASHINGTON, DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE AVERY	
14. MOTHER'S MAIDEN NAME MAY MORAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT ELMER W. AVERY, 8328 QUENTIN ST., CARROLLTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 181.0 DUE TO carcinoma of bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) carcinoma of bladder (c) carcinoma of bladder INTERVAL BETWEEN ONSET AND DEATH 5 Months			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/27/60 to 12/15/60 19.60 that (I) last saw the deceased alive on 12/14/60 19.60, and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur J. Wilets		22b. ADDRESS 1015 Spring St., Silver Spring, Md.	
22c. PHYSICIAN'S NAME (Type) Arthur J. Wilets, M. D.		22d. ADDRESS 1015 Spring St., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 19, 1960	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Ziska		25a. REC'D BY REGISTRAR DEC 22 '60	
25b. REGISTRAR'S SIGNATURE Richard S. Knecht		25c. DATE DEC 22 '60	

IN SENATE,

January 11, 1911.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE.

PRESENTED TO THE SENATE,

BY THE COMMISSIONER.

ALBUQUERQUE, N. M.,

1911.

PRINTED BY THE

GOVERNMENT PRINTING OFFICE.

U. S. DEPARTMENT OF THE INTERIOR,

BUREAU OF LAND MANAGEMENT.

WASHINGTON, D. C.,

1911.

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139811

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
3. NAME OF DECEASED (Type or print) Helen		First E		Middle Chickson		Last BAKER		4. DATE OF DEATH Month December	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-4-97		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative		10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME William CLARKSON		15. MOTHER'S MAIDEN NAME Victoria LANHAM		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO.		18. INFORMANT (D) Mrs. Jane B. Brant, same as #2 above	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe brain damage 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Malignant brain tumor DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		25a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
26a. (City or town)		26b. (County)		26c. (State)		27. I certify that (X) (this hospital) attended the deceased from Nov. 30 1960 to Dec. 5 1960 that (X) (we) last saw the deceased alive on Dec. 5 1960 , and that death occurred at 1:50AM from the causes and on the date stated above.		28. SIGNATURE Barclay W. Shepard M.D.	
29a. PHYSICIAN'S NAME (Type) Barclay W. SHEPARD, LT, MC, USN		29b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		30a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		30b. DATE 12-5-60		31. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
32a. DATE THEREOF 12-6-60		32b. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		32c. LOCATION (City, town, or county) Suitland		32d. (State) Maryland		33. REG'D BY REGISTRAR DATE DEC 7 '60	
34. REGISTRAR'S SIGNATURE R. A. Humphrey		34b. ADDRESS Funeral Home, Bethesda, Md.		34c. REGISTRAR'S SIGNATURE Arthur S. Kins...		34d. DATE		34e. DATE	

11-25

STATE OF MICHIGAN

11-25

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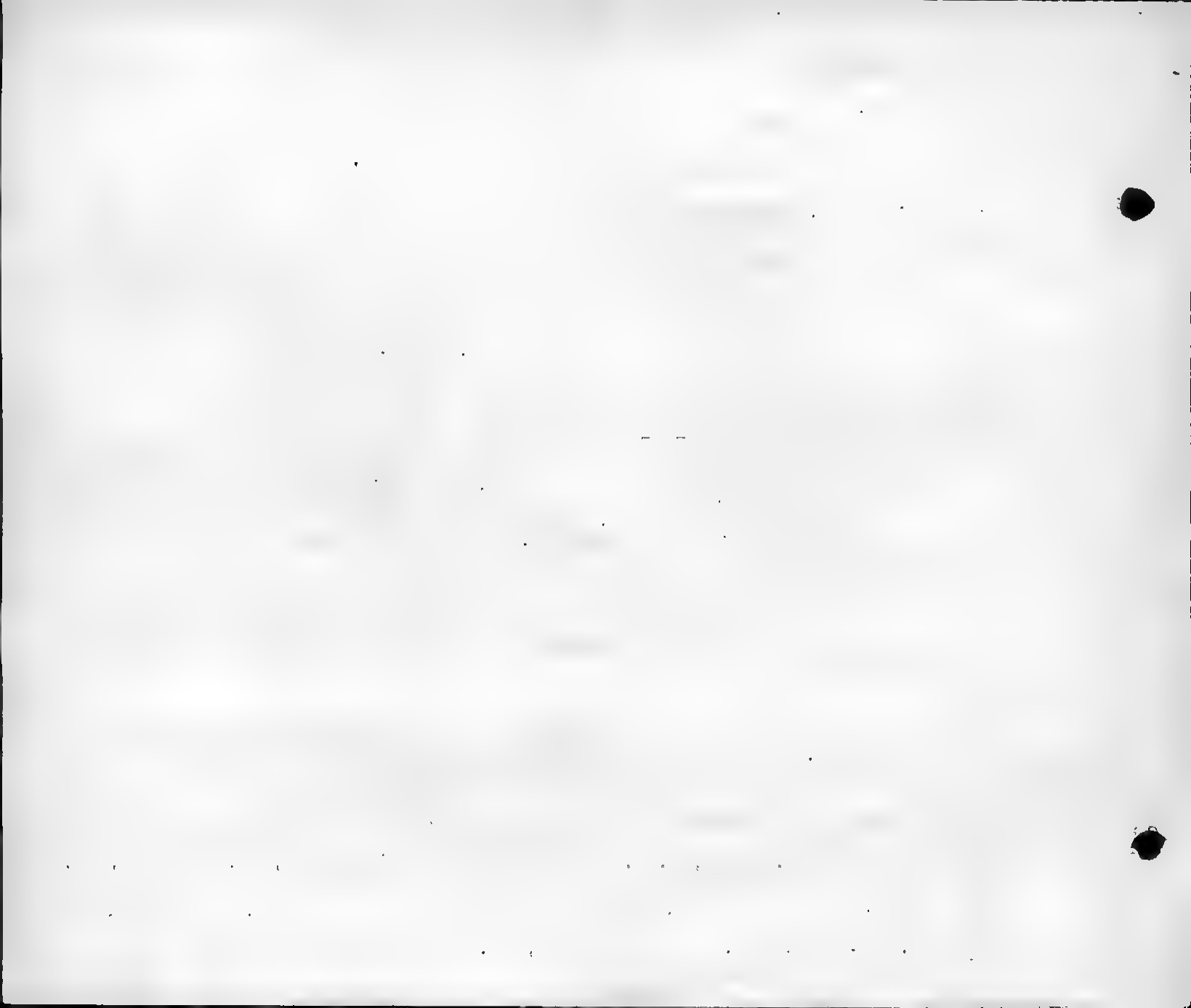
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14021

13861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Y. X</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>17 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>503 Empress Ct.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>SMITH</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> - DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1980</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>80</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Elias Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>147-05-3182</u>	
17. INFORMANT <u>Daughter (Mrs. Glendia Bork)</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, papillary, left kidney</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>with metastasis to bladder</u> (c) <u>180X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(husband)</u> attended the deceased from <u>April 16, 1958</u> to <u>December 20, 1960</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Dec 19</u> 19 <u>60</u> , and that death occurred at <u>12:35 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Aaron H. Traum</u> M.D.		22b. DATE SIGNED <u>Dec 21, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M. D.</u>		22d. ADDRESS <u>8237 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF <u>12/22/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>	23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

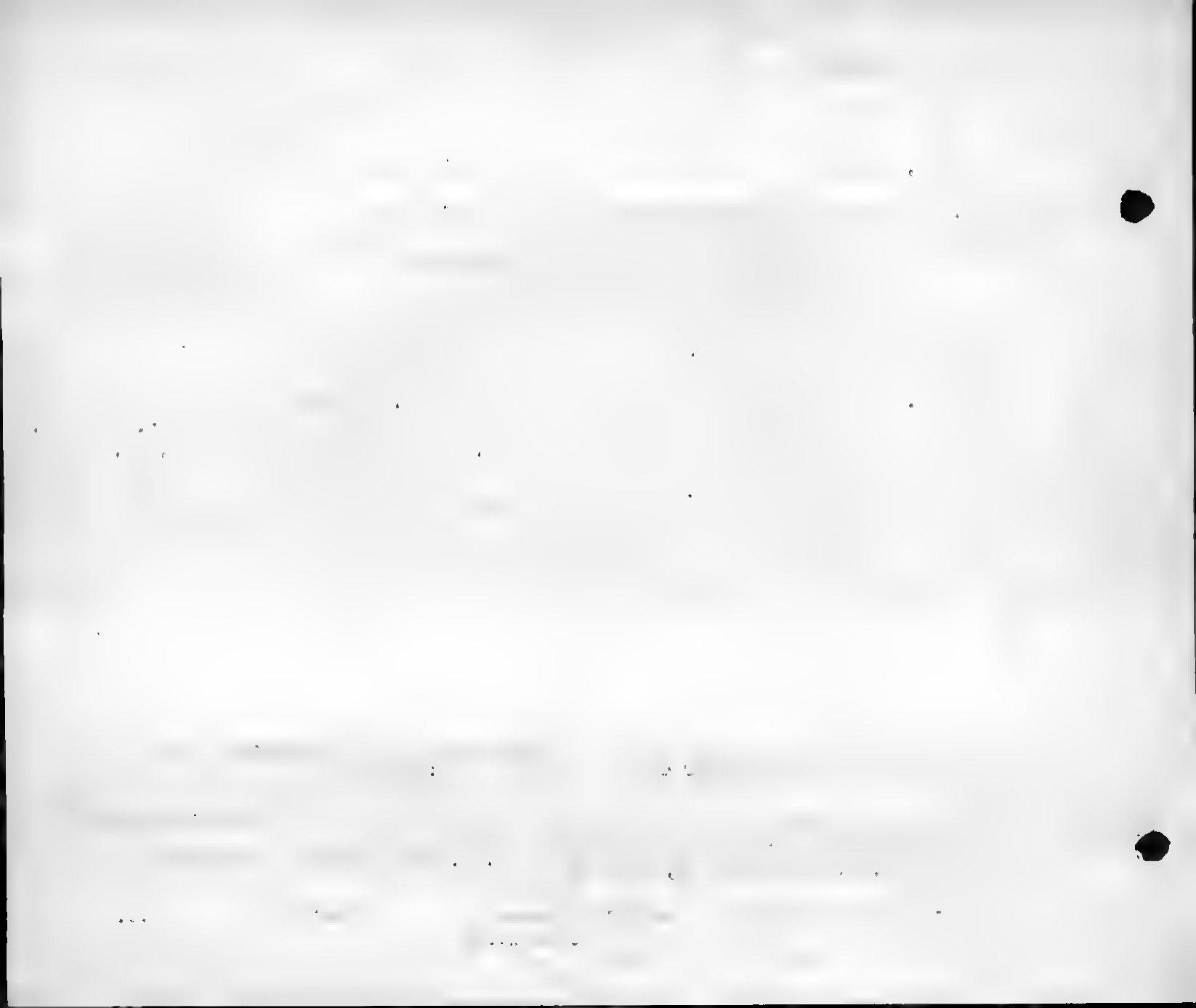
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Pennsylvania b. COUNTY Manheim	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Bethesda, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manheim	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First David Middle Alan Last Bashore		4 DATE OF DEATH Month December Day 3 Year 19 60	
5 SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-17-57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Ralph W. Bashore		14. MOTHER'S MAIDEN NAME Marion C. Mc Manus	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17 INFORMANT Ralph W. Bashore (Father)		Address 132 S. Main St. Manheim, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 Congenital heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) since birth DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 November 1960 , to 3 December 1960 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3 December 1960 , and that death occurred at 8:30A M, from the causes and on the date stated above			
22a. SIGNATURE C. W. Bramlett		22b. DATE SIGNED 3 December 1960	
22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-4-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens		23d. LOCATION (City, town, or county) (State) Charleston S.C.	
24 FUNERAL DIRECTOR'S SIGNATURE K.A. Ruyley Funeral Home		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE DATE DEC 6 '60		25c. REGISTRAR'S SIGNATURE Arthur S. Huns	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13983

14088

Item 8 Film G2.8 1-3-61 et

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Francis Baumer</u>		f. STREET ADDRESS <u>205 E Argyle Ave</u>	
4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1960</u>		g. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1951</u>
7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <u>8</u> yrs	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Robert Baumer</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Kathleen Smith Baumer (mother)</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral edema</u>			
DUE TO (b) <u>Cerebral aneurysm</u>			
DUE TO (c) <u>Basal Skull Fracture</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Reflected to rear across st. in front of truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-21-1960</u> Hour <u>3:22</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-22-60</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>12/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. J. Wheeler</u>		24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>	
ADDRESS <u>Wheeler Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. E. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

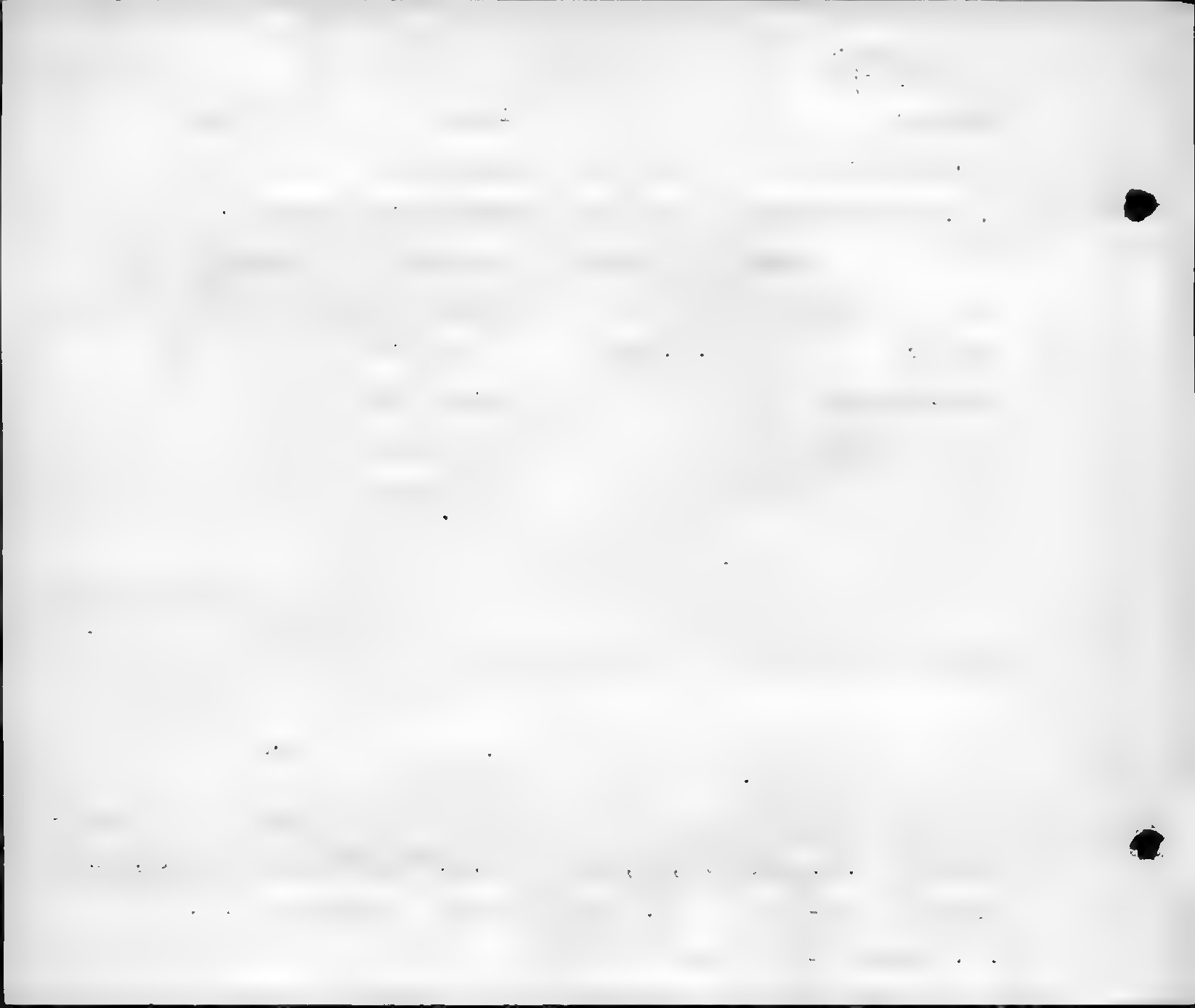
CERTIFICATE OF DEATH

14089

Items 1, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

13984

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 128 97 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia		b. COUNTY Arlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		d. STREET ADDRESS 5404 N. Carlyn Springs Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert		Middle Alden		Last BEAVERS		4. DATE OF DEATH Month December		Day 24		Year 19 60					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-30-28		9. AGE (in years last birthday) 32 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy				11. BIRTHPLACE (State or foreign country) California				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James BEAVERS						14. MOTHER'S MAIDEN NAME Marlyn TREAT Marion Treat									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1946 to 1960				17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empyema, Organism unknown DUE TO (b) Hepatic Abscesses DUE TO (c) Pancreatitis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from Aug. 18 , 19 60 , to Dec. 24 , 19 60 , that (X) (we) last saw the deceased alive on Dec. 24 , 19 60 , and that death occurred at 4P. M., from the causes and on the date stated above															
22a. SIGNATURE V. N. HOUK, LCDR, MC, USN				22b. PHYSICIAN'S NAME (Type) U. S. Naval Hospital, Bethesda, Md.				22c. ADDRESS WashDC				22d. DATE 12-25-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 12-30-60				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory				23d. LOCATION (City, town, or county) (State) Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				25a. REC'D BY REGISTRAR DEC 29 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Howe							



14022

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13985

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Bennett</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 20, 1960</u>	9 AGE (In years last birthday) yrs <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>39</u> Hours <u>25</u>	F UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry John Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Lottie Elizabeth Harber</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Father - Same as Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>77X</u> DUE TO <u>PREMATURITY</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21 I certify that (I) (this hospital) attended the deceased from <u>12-20</u> <u>1960</u> to <u>12-22</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>12-21</u> <u>1960</u> , and that death occurred at <u>3:30 A</u> , from the causes and on the date stated above							
22a SIGNATURE <u>Carolyn S. Pincock</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12-22-60</u>				
22c PHYSICIAN'S NAME (Type) <u>CAROLYN S. PINCOCK</u>		22d ADDRESS <u>1944-Seminary Road S.S.</u>					
23a BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>12-23-60</u>	23c NAME OF CEMETERY OR CREMATORY <u>—</u>		23d LOCATION (City, town or county) (State)			
24 FUNERAL DIRECTOR'S SIGNATURE <u>—</u>		ADDRESS <u>—</u>		25a REC'D BY REGISTRAR <u>—</u> DATE <u>12/27/60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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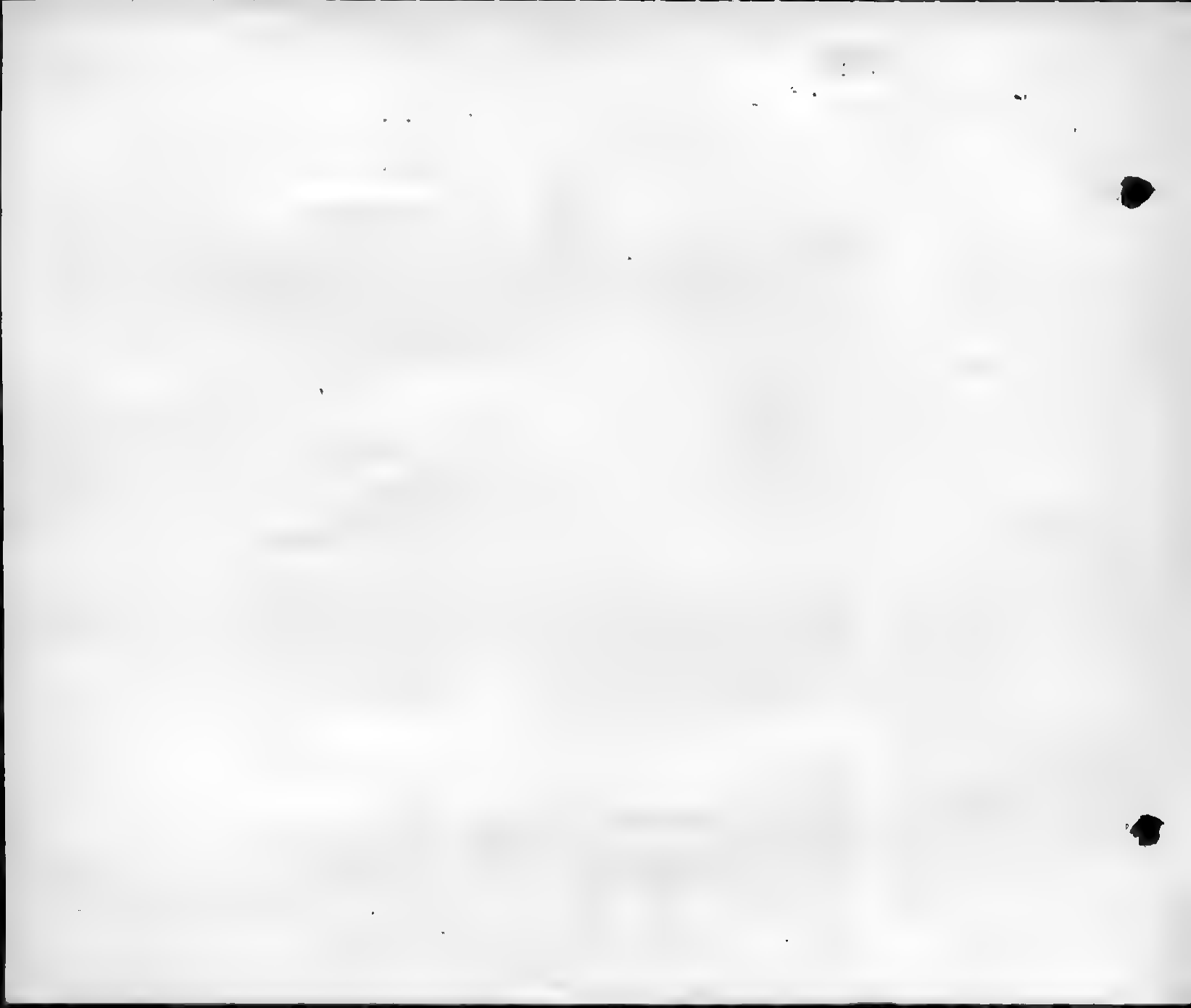


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14090
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13986

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD. (D.C.) b. COUNTY MONTG. MARY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN lb 15 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f STREET ADDRESS 5210 Wisconsin Road		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle L. Benoit Last		4. DATE OF DEATH Month 12 Day 26 Year 1960	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-30-08
9 AGE (In years last birthday) 52 yrs		10 UNDER 1 YEAR Months 5 Days 2 Hours 1 Min.	11 UNDER 24 HRS Hours 1 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b KIND OF BUSINESS OR INDUSTRY Rhode Island	
11 BIRTHPLACE (State or foreign country) U.S.A		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME Thos. R. Ludgate		14 MOTHER'S MAIDEN NAME Gertrude Williams	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No		16 SOCIAL SECURITY NO (If yes, give war or dates of service)	
17 INFORMANT Husband (Henry Benoit)		Address Same as above	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction 420.0 DUE TO (b) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild diabetes mellitus + generalized arteriosclerosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 12/11 19 60 to 12/26 19 60 that (I) (we) last saw the deceased alive on 12/26 19 60 , and that death occurred at 12/26 19 60 , from the causes and on the date stated above		22a SIGNATURE Thomas F. O'Connor M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR		22d ADDRESS 4861 BATTERY LANE BETHESDA, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-29-60	
23c NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia.		23d LOCATION (City, town, or county) (State)	
24 FUNERAL DIRECTOR'S NAME (Type) ROBERT A. PUMPHREY		25a REC'D BY REGISTRAR DATE DEC 29 '60	
25b REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14062

CERTIFICATE OF DEATH

13087

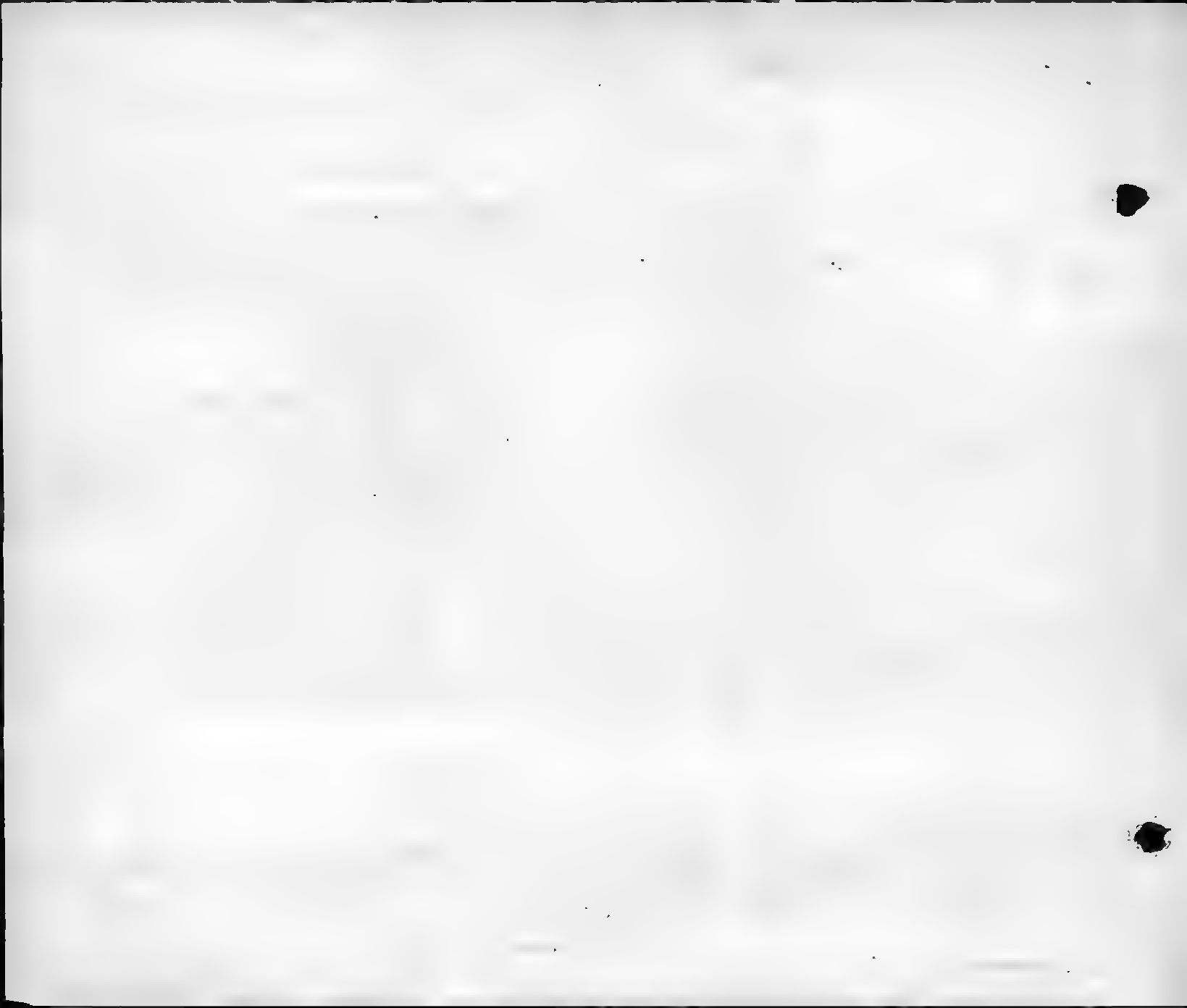
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6807 Conn. Ave.</u>				d. STREET ADDRESS <u>6807 Conn. Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Eligabeth Richardson Bessey</u>				4. DATE OF DEATH <u>Dec 5 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19, 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Frank Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Summers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Daughter - Jean Browning Bethesda</u>				Address <u>5409 Ireland Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>Oct. 1960</u> to <u>Dec 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov. 25 1960</u> , and that death occurred on <u>9 A</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Marvin Wadler</u>				22b. DATE SIGNED <u>12/5/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>				22d. ADDRESS <u>8218 Wisconsin Av, BETH, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/7/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
25a. REC'D BY REGISTRAR <u>DATE DEC 6 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

(M)

(I)

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

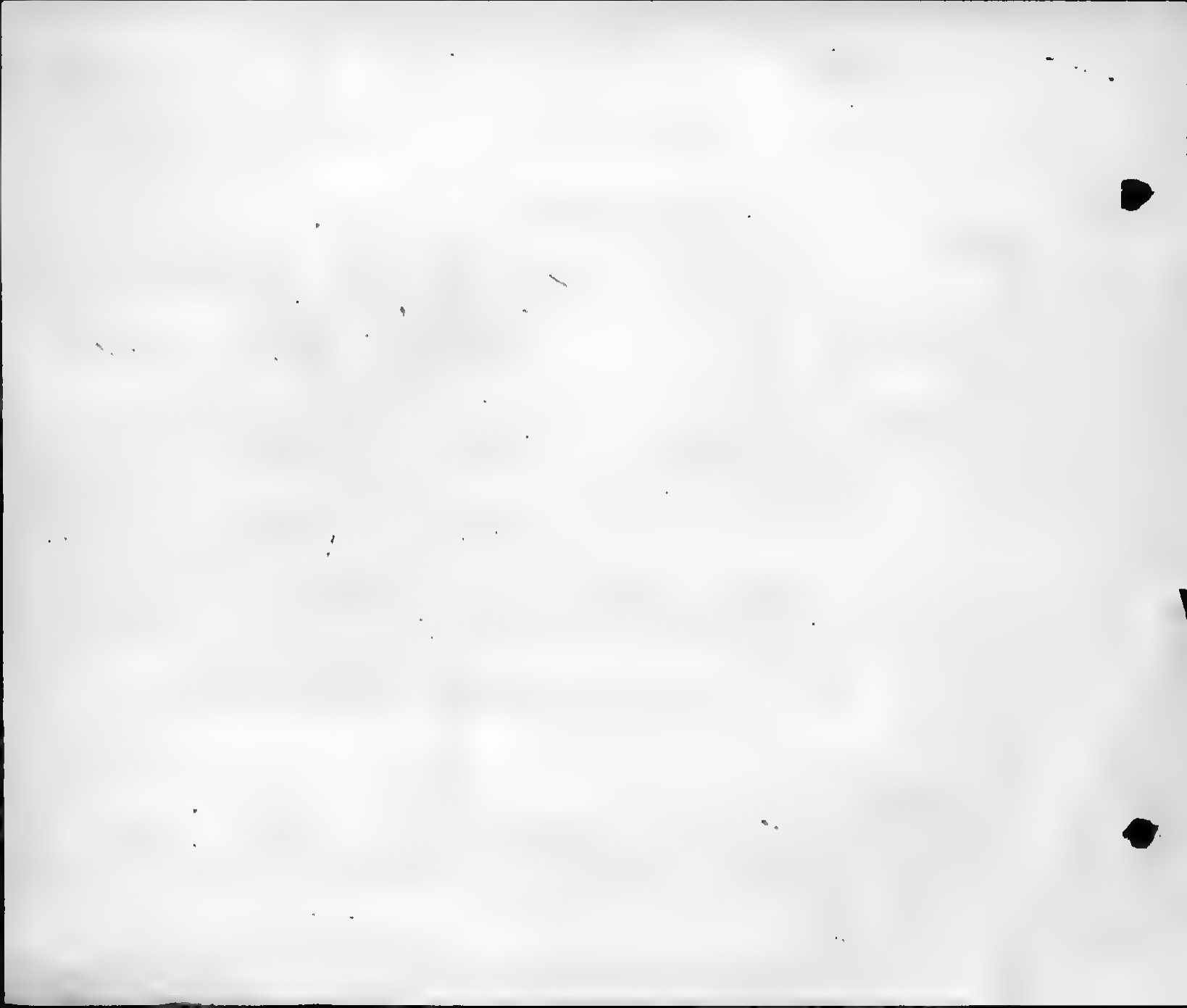
CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14091

CERTIFICATE OF DEATH

13988

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Alta Vista Nursing Home</i>		d. STREET ADDRESS <i>3236 N St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Eleanor</i> Middle <i>Birnie</i> Last <i>Birnie</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>25</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 5 1887</i>
9. AGE (In years last birthday) <i>73</i> yrs		IF UNDER 1 YEAR: Months <i>7</i> Days <i>10</i> Hours <i>10</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>TANEY TOWN MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Birnie</i>		14. MOTHER'S MAIDEN NAME <i>Zollie Kopper</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>McL. Birnie Jr. 432 E. D. Ave.</i>		Address <i>State College, Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <i>Transition and malnutrition</i> (b) <i>Arthritis of Hips and Spine, and</i> (c) <i>Generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Partial intestinal obstruction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>10 years</i> <i>20+ years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>p. m.</i> <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>June 27, 1958</i> to <i>Dec 25, 1960</i> ; that (I) <i>lost</i> saw the deceased alive on <i>Dec 8, 1960</i> and that death occurred at <i>5:35 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>R. Stephen Hulbert</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>R. Stephen Hulbert, MD</i>		22d. ADDRESS <i>3000 Dent Place NW, Washington DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-28-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>PINEY CREEK</i>		23d. LOCATION (City, town, or county) (State) <i>TANEY TOWN MD</i>	
24a. REGISTRAR'S SIGNATURE <i>Robert A. Humphrey</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	
24c. ADDRESS <i>1557 Wisconsin Ave. Bethesda, Md.</i>		24d. DATE <i>DEC 29 '60</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

18988

FOR STATE
HEALTH DEPT.

14092

Item 7 Film G277 12-21-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 12 hrs.		d. STREET ADDRESS 456 Caledonia Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital			
3. NAME OF DECEASED (Type or print) First Edna Middle V Last Bowser		4. DATE OF DEATH Month December Day 12 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1898
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR: Months 13 Days 13 Hours 13 M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Sewing	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U/S	
13. FATHER'S NAME William Adams		14. MOTHER'S MAIDEN NAME Ann Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 191-10-5872	
17. INFORMANT Penna. Funeral Director-Philipsburg, Pa		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) 33 IX DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 12 Day 15 Year 19 60 Hour 11 a. m. 11 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brosch M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) FRANK J. Brosch		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Bur-Transit 12/15/60		22b. DATE THEREOF 12-12-60	
22c. NAME OF CEMETERY OR CREMATORY Philipsburg Cemetery		22d. LOCATION (City, town, or county) (State) Centre Co. Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 15 '60	
24b. REGISTRAR'S SIGNATURE Clifford L. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PG-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14000

CERTIFICATE OF DEATH

Reg. Dist. No.

13990

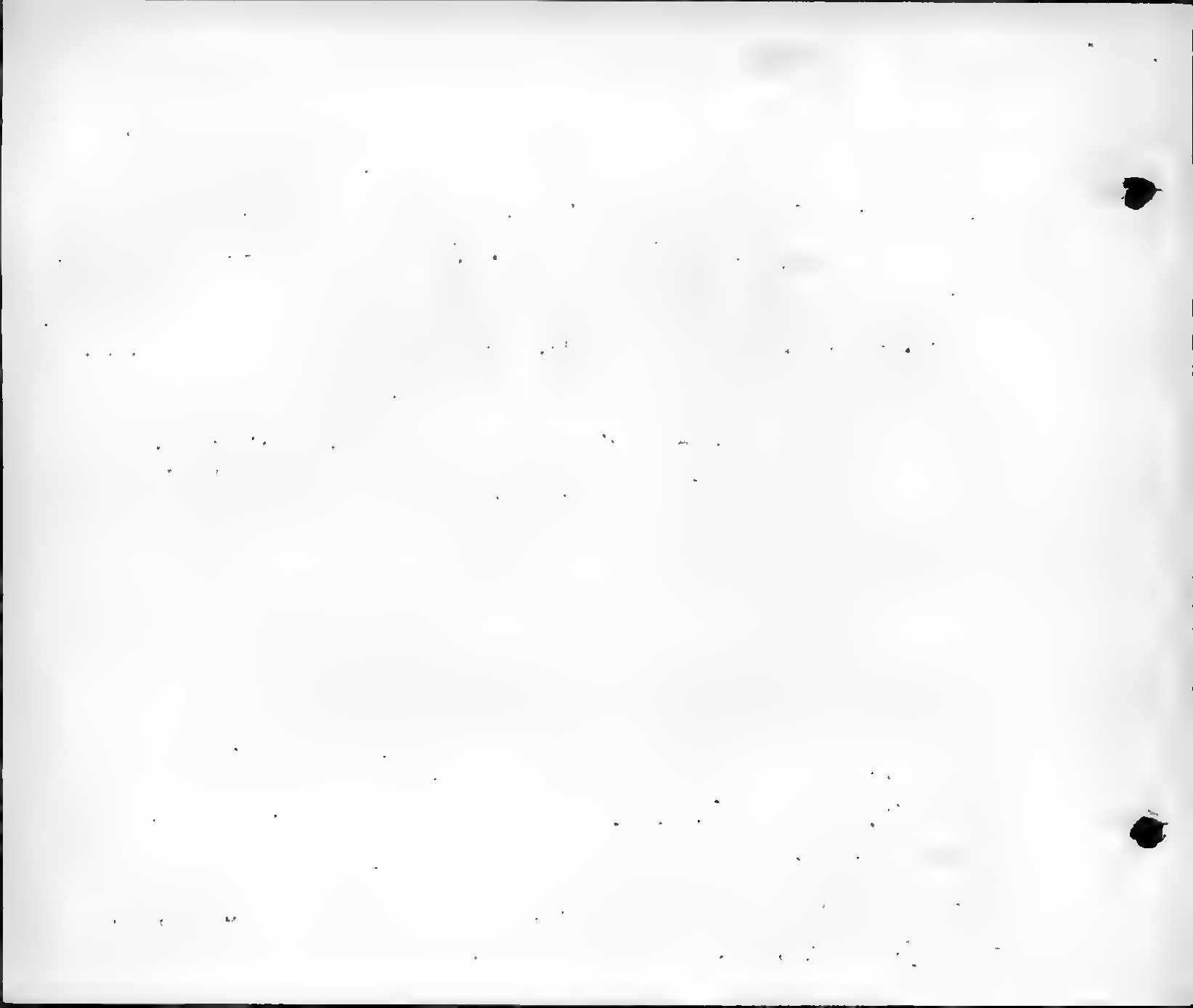
1. PLACE OF DEATH o COUNTY <u>Montgomery</u> o STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>345 University Blvd, West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>HOMER</u> Last <u>Bracken</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/23</u>
9. AGE (In years last birthday) <u>37</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Amer. Psychological Ass'n.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOMER BRACKEN</u>		14. MOTHER'S MAIDEN NAME <u>unknown JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW # 2</u>		16. SOCIAL SECURITY NO <u>193-14-6429</u>	
17. INFORMANT <u>Leona Bracken</u>		Address <u>10,204 Calumet Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X Myocardial infarction</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 26, 1958</u> , to <u>Dec 28, 1960</u> , that I last saw the deceased alive on <u>Dec 28, 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> , M.D.		DATE SIGNED <u>12/28/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>		ADDRESS (Street, city or town, state) <u>345 University Blvd, West Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>DATE 4 '61</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



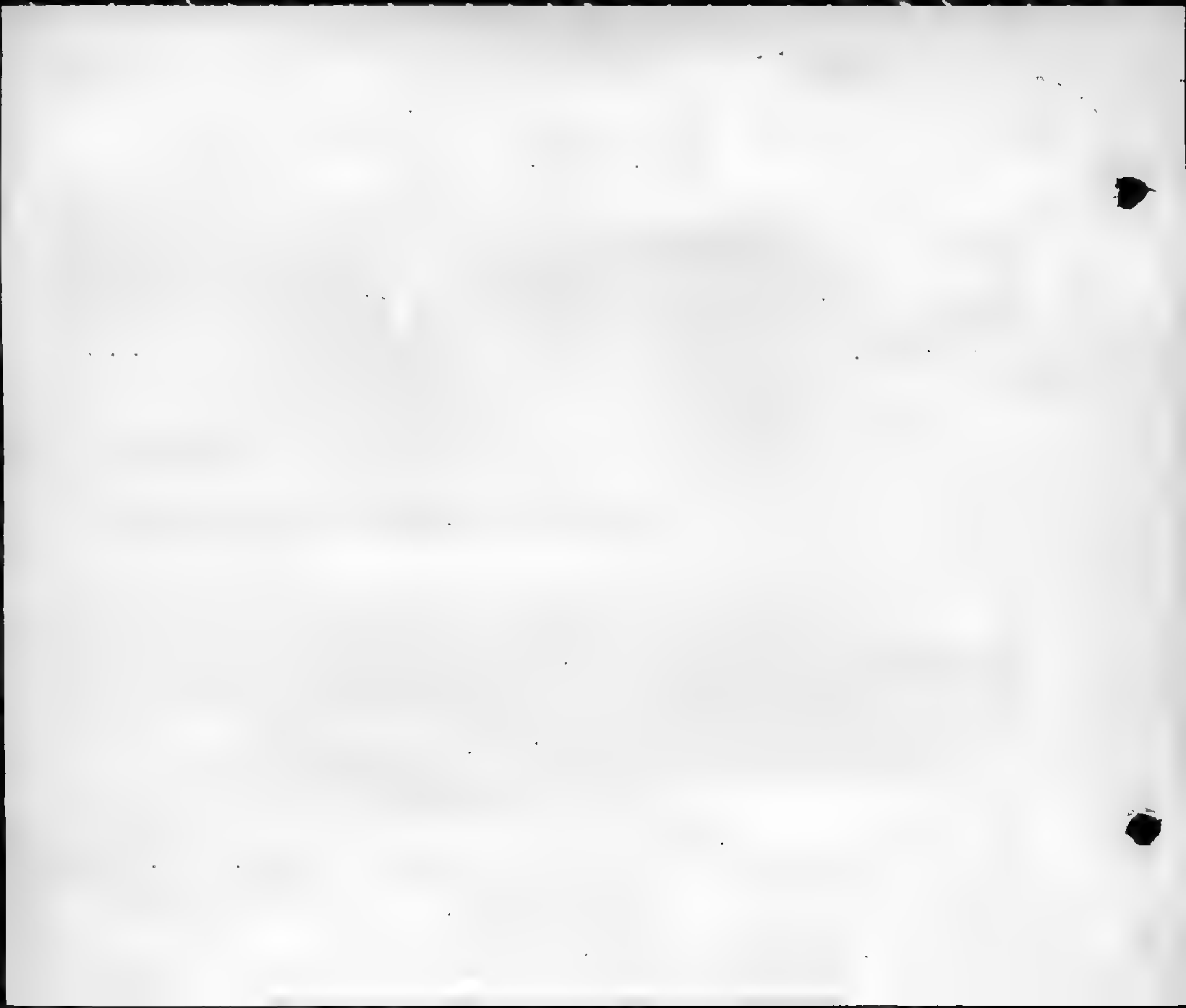
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14093

13991

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 mos. 14 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 8500 Rosewood Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Katherine M Bradley				4. DATE OF DEATH Month 12 Day 12 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 5 1873		9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hswf.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Mc Donald				14. MOTHER'S MAIDEN NAME Mary Benton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Daughter (Mrs. Katherine Bell (Same as above))			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 331 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Generalized Cerebral Ischemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12-60 to Dec 12 , 19 60 , that (I) (we) last saw the deceased alive on Dec 12 , 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above							
22a. SIGNATURE Wm. T. Joyce				22b. DATE SIGNED 12/12/60		22c. PHYSICIAN'S NAME (Type) Wm. T. Joyce	
22d. ADDRESS 8106 Maple Ridge Rd. Beth. Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 20 60	
				25b. REGISTRAR'S SIGNATURE <i>Charles E. Jones</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brochart notified

14094

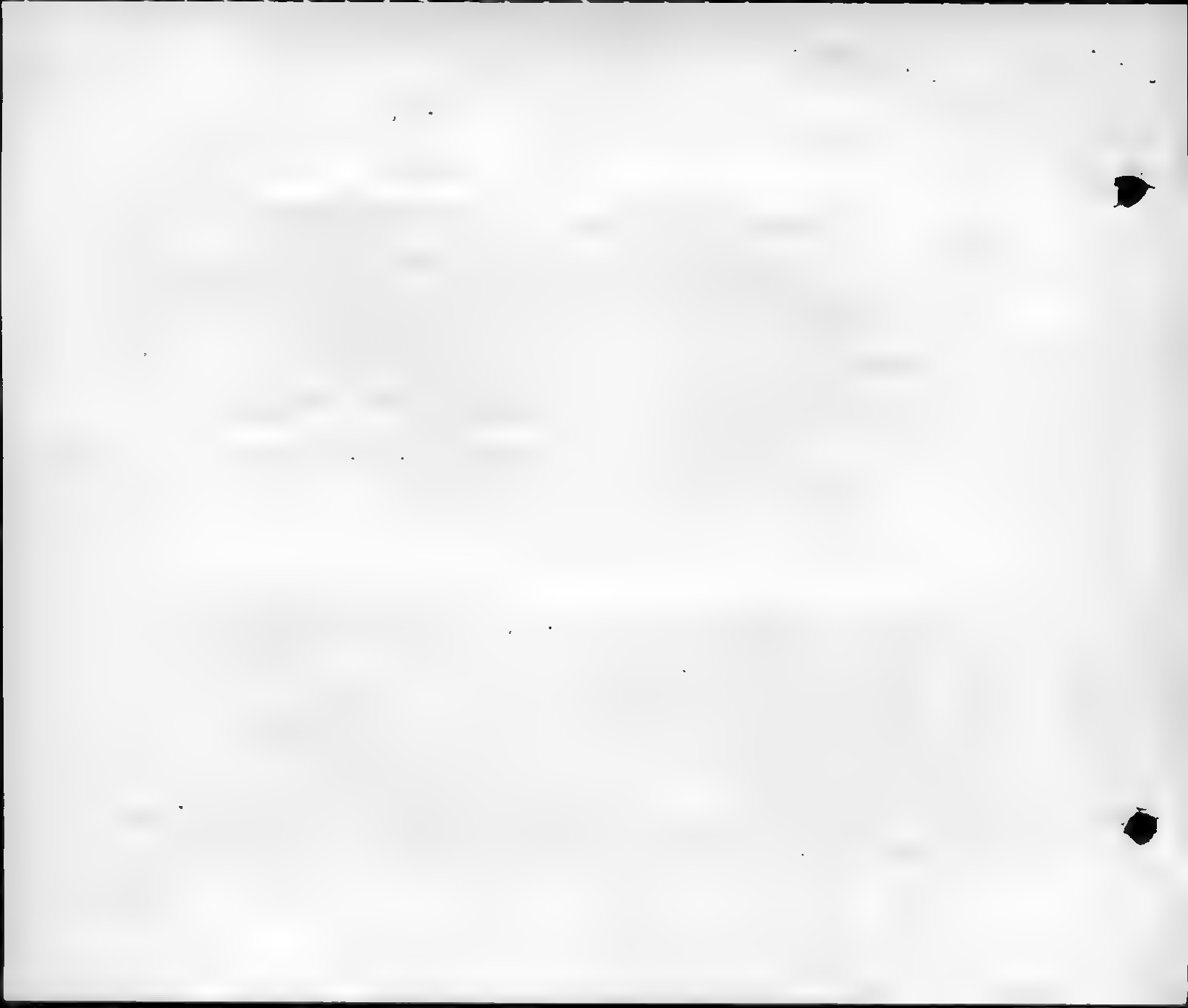
13992

74

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle C Last hiles		4. DATE OF DEATH Month Dec. Day 26 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1882
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME William O. Bradley	
14. MOTHER'S MAIDEN NAME Laura Moffatt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter (Mrs. Donald Deane)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: 1491X IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) 1 week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip & Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Yes		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell while walking on icy pavement	
20c. TIME OF INJURY Month 12 Day 17 Year 1960 p. m. 7:45		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. CITY OR TOWN (County) (State) Bethesda Mont Md	
21. I certify that (I) (this hospital) attended the deceased from Dec 17 1960 to Dec 26 1960, that (I) (we) last saw the deceased alive on Dec 25 1960, and that death occurred at 7:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. O'Connor		22b. DATE SIGNED 12/26/60	
22c. PHYSICIAN'S NAME (Type) Thomas O'Connor		22d. ADDRESS 4861 BATTERY LANE, BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DEC 29 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE C. E. ...	

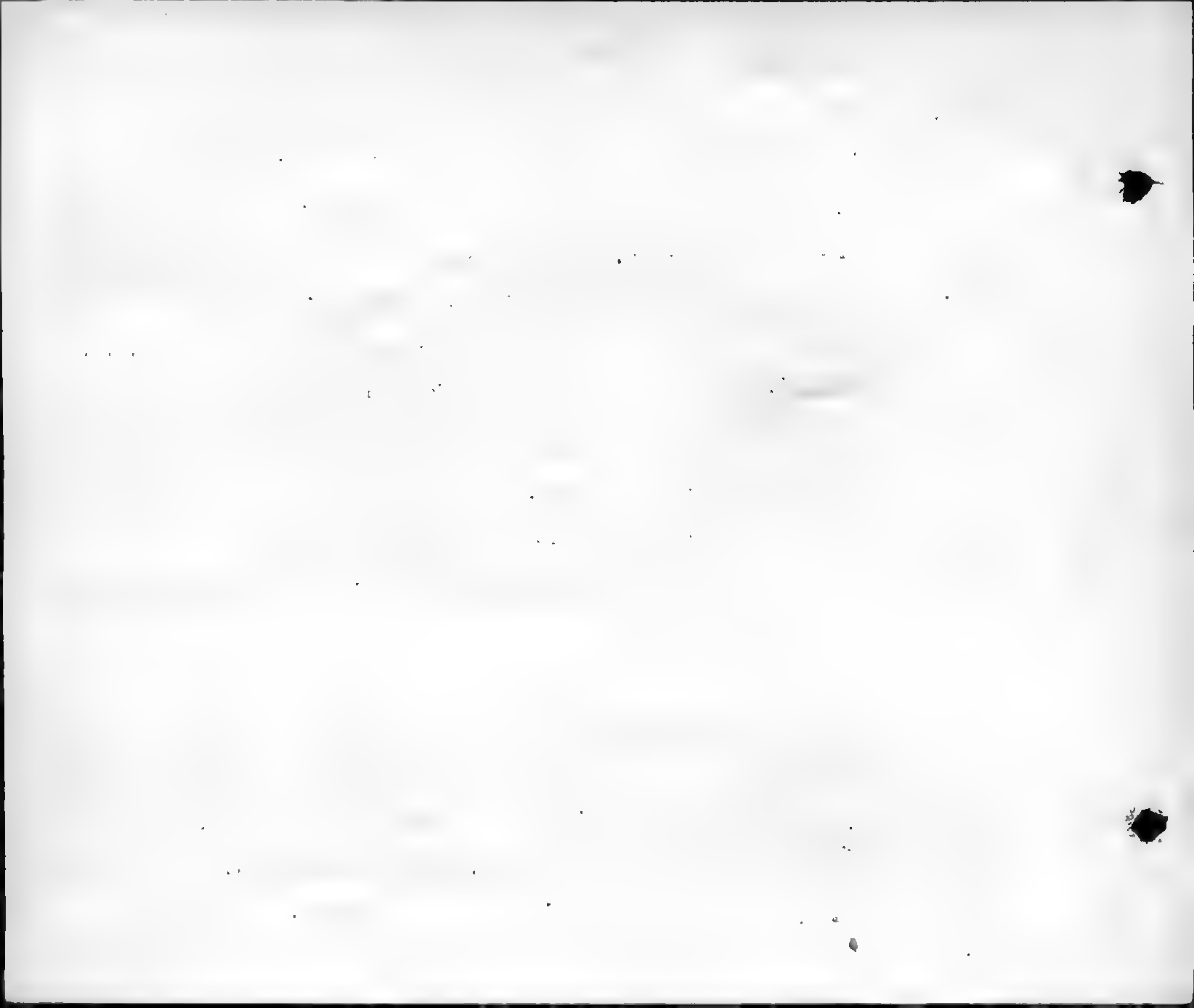


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
14073					CERTIFICATE OF DEATH					
Reg. Dist. No. 12993										
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3907 Hampden Street					d. STREET ADDRESS 13907 Hampden Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Mae Middle Florence Last Briseoe					4. DATE OF DEATH Month December Day 11 Year 609					
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 22 1894		9. AGE (In years last birthday) 66 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel P. Jackson					14. MOTHER'S MAIDEN NAME Bell Doye					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			16. SOCIAL SECURITY NO.		INFORMANT Address Glenwood Bailey - Silver Spring, Route # 1					
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH 2 hours		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis										
DUE TO (b) Coronary Arteriosclerosis										
DUE TO (c) Hypertensive Cardioresnal Disease										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Gallbladder Trouble										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/6/57 , 19__ to 12/11/60 , 19__, that I last saw the deceased alive on 12/11/60 , 19__, and that death occurred at 4:53 AM , from the causes and on the date stated above.										
ACTUAL SIGNATURE Webster Sewell M.D.					ADDRESS (Street, city or town, state) Norbeck DATE SIGNED 12/16/60					
PHYSICIAN'S NAME (Type) Webster Sewell					Rt. 1 Silver Spring, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/60		22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		22d. LOCATION (City, town, or county) (State) Clarke County, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Snowden					ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE DEC 22 '60		24b. REGISTRAR'S SIGNATURE C. L. F. Finner	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

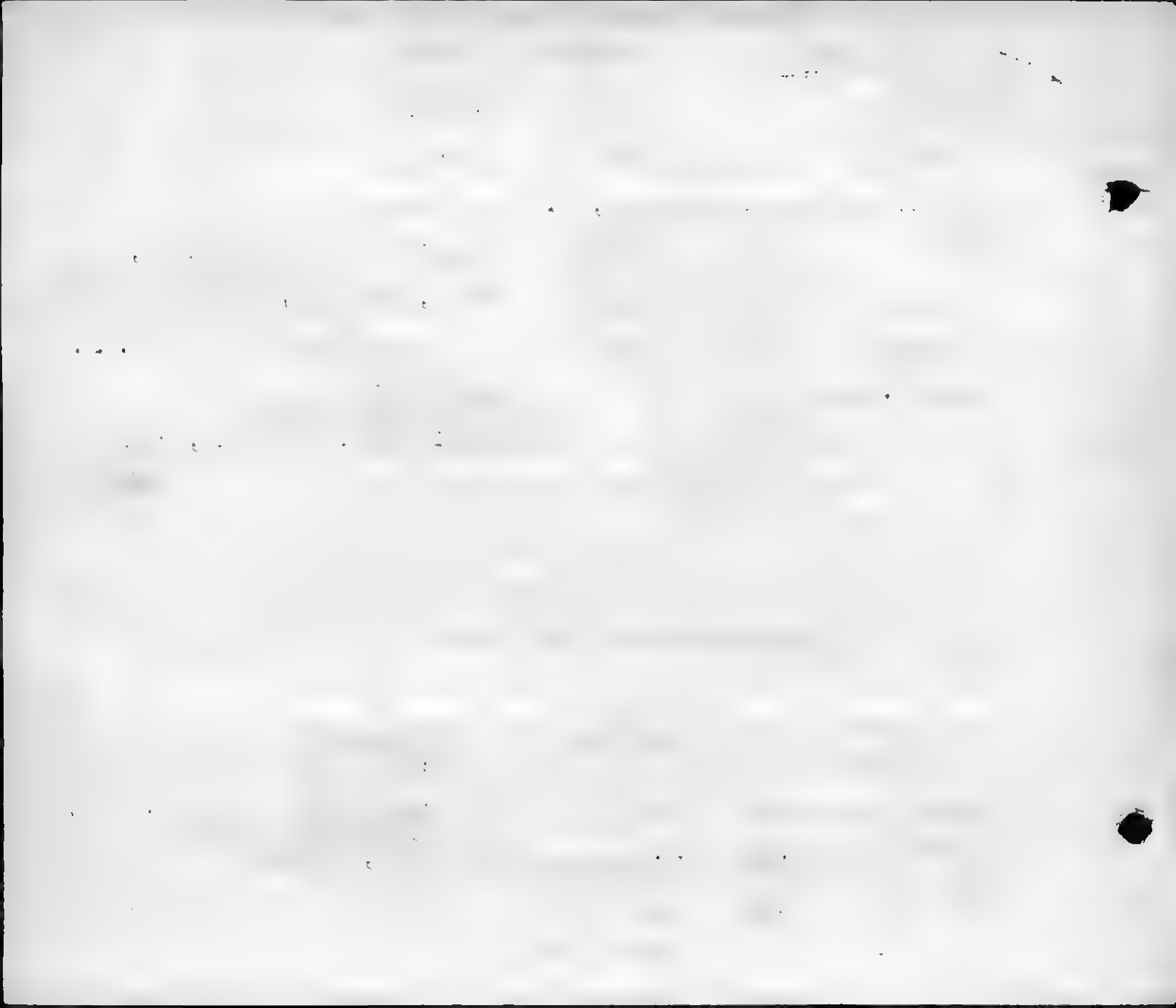
CERTIFICATE OF DEATH

Reg. Dist. No.

13994

14095

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Pennsylvania b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 538 Castner Avenue			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle (None) Last Brizzi		4. DATE OF DEATH Month December Day 8 Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1953				
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None					
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James V. Brizzi		14. MOTHER'S MAIDEN NAME Marie Iuzzi					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None					
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocarcinoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 2001 DUE TO (c) 2001 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2001							
INTERVAL BETWEEN ONSET AND DEATH 1 mo							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from November 30 , 19 60 , to December 8 , 19 60 , that I last saw the deceased alive on December 8 , 19 60 , and that death occurred at 11:23P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/9/60 ACTUAL SIGNATURE Edward E. Morse M.D. The Clinical Center PHYSICIAN'S NAME (Type) Edward E. Morse M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/60					
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Sem.		22d. LOCATION (City, town, or county) (State) Monogahela, Penna.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 15 '60					
24b. REGISTRAR'S SIGNATURE <i>William S. K...</i>							



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

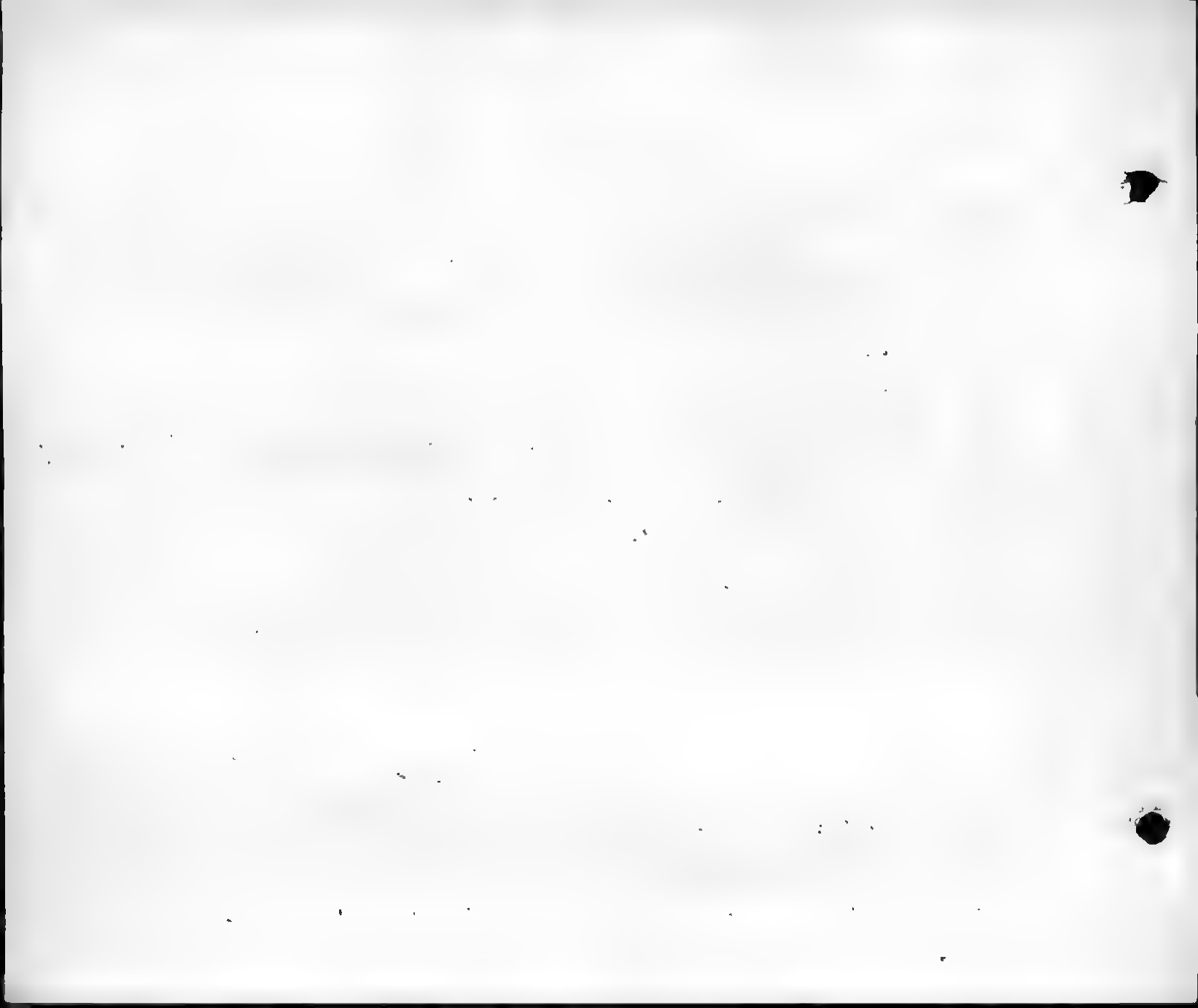
14001

CERTIFICATE OF DEATH

Reg. Dist. No.

13095

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME		d. STREET ADDRESS 11504 REGNID DRIVE	
3. NAME OF DECEASED (Type or print) First BETTY Middle Brown Last Brown		4. DATE OF DEATH Month DECEMBER Day 16 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1870
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY RIGA, LATVIA	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB WOFSY		14. MOTHER'S MAIDEN NAME RACHEL KAPLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO INFORMANT Address MRS. ISRAEL ROTKIN 11504 REGNID DRIVE. SS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis & Heart problem		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/2 , 19 57 , to 12/16 , 19 60 that I last saw the deceased alive on 12/14 , 19 60 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen L. Jones M.D.		ADDRESS (Street, city or town, state) 22nd St, Silver Spring, Md DATE SIGNED 12/16/60	
PHYSICIAN'S NAME (Type) STEPHEN L. JONES, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-18-60	22c. NAME OF CEMETERY OR CREMATORY MT WASHINGTON CEM.	22d. LOCATION (City, town, or county) (State) LONG ISLAND - N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY SONS - 3501-14757 NW		24a. REC'D BY REGISTRAR DEC 19 1960 24b. REGISTRAR'S SIGNATURE C. J. S. Jones	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

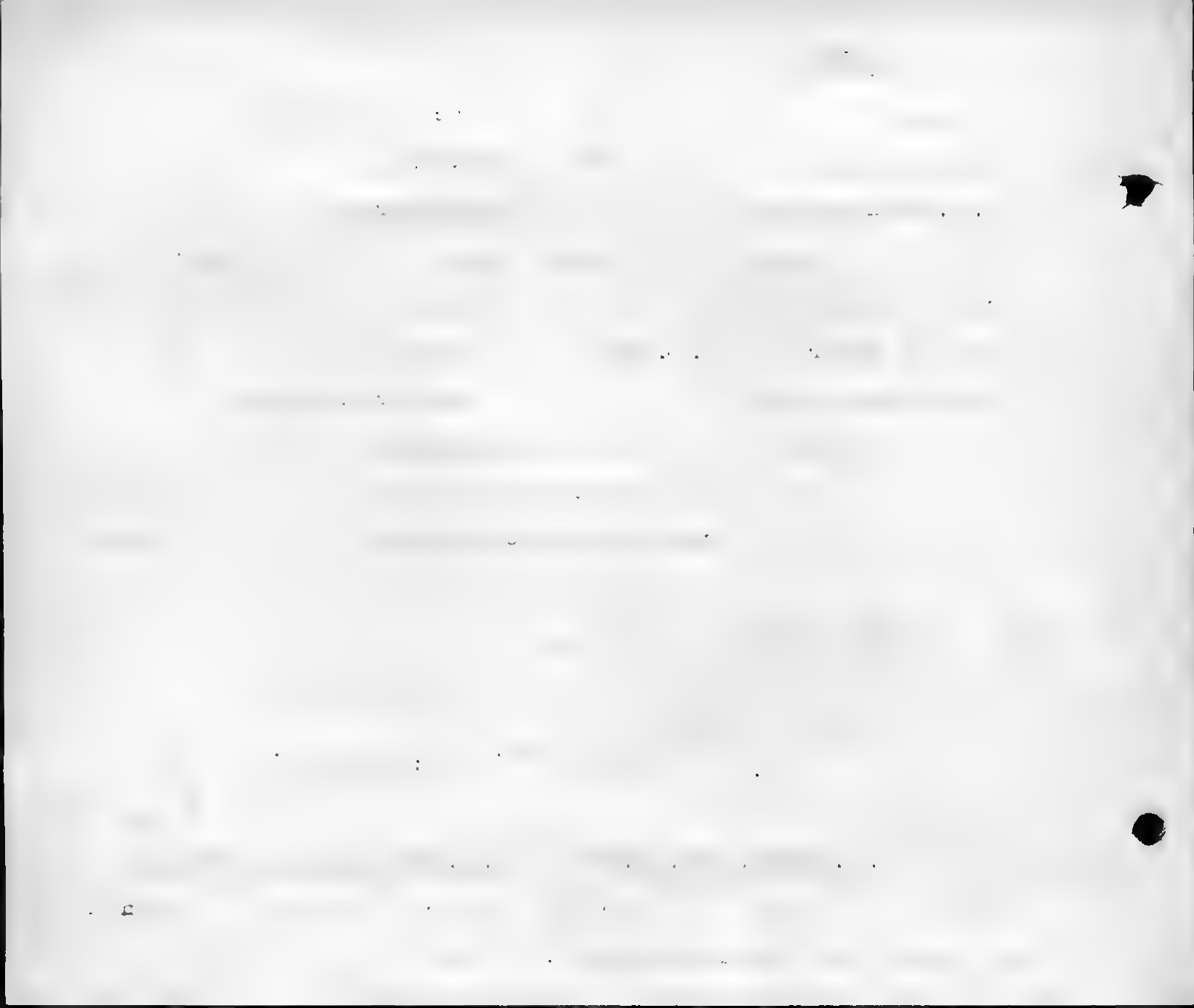
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14096

13996

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 4000 Cathedral			
3. NAME OF DECEASED (Type or print) First Ernest Middle William Last BROWN				4. DATE OF DEATH Month December Day 23 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-78	
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Connecticut	
12. C T ZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Harris BROWN				14. MOTHER'S MAIDEN NAME Mary Cornelia DOWLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1903-1942		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Arterioscleortic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioscleortic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture, left hip							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (he (this hospital) attended the deceased from Dec. 18 1960 to Dec. 23 1960 , that (he) (we) last saw the deceased alive on Dec. 23 1960 , and that death occurred at 9:32 AM from the causes and on the date stated above.							
22a. SIGNATURE M. C. Wilber				M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-23-60	
22c. PHYSICIAN'S NAME (Type) M. C. WILBER, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-24-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph S. Gowers ADDRESS WashDC				25a. REC'D BY REGISTRAR DEC 29 '60		25b. REGISTRAR'S SIGNATURE William S. Frank	



14063

2997

1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Chevy Chase		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		55 Chevy Chase		d. STREET ADDRESS		4608 Langdrum Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		4608 Langdrum Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print)		First		Middle		Last	
Fredrick		W		Browne		4. DATE OF DEATH		Month		Day		Year	
December		16		19		60		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Male		White		Oct. 25, 1875		9. AGE (In years last birthday) yrs.		85		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		Brig. Gen.-ret.		U. S. Army		Iowa	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)	
William L. Browne		Mary Meclure		Yes		213-40-4610		William L. Browne-son-same		2d		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/16/60		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/20/60		22c. NAME OF CEMETERY OR CREMATORY		Arlington Nat. Cem		22d. LOCATION (City, town, or county)		Arlington, Virginia		22e. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		Robert A. Pumphrey		ADDRESS		Bethesda, Maryland		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DEC 21 '60	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1

14020

13998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sav. & Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>	
		d. STREET ADDRESS <i>9314 WARREN ST. 1</i>	
3. NAME OF DECEASED (Type or print) <i>Peggy Lee Buddard</i>		4. DATE OF DEATH <i>12 26 19 60</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/27/91</i>
9. AGE (In years last birthday) <i>69</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>James Earl</i> Unknown FAIRCLOTH		14. MOTHER'S MAIDEN NAME <i>MIMIE</i> unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>Sp't Hospital record.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage & shock</i> <i>330X</i> DUE TO <i>arterial degeneration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension plus arterial wall changes</i> (c) <i>Modular growth</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Modular growth</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/26/1960</i> to <i>12/26/1960</i> , that (I) (we) last saw the deceased alive on <i>12/26/1960</i> and that death occurred at <i>12/26/1960</i> M. from the causes and on the date stated above			
22a. SIGNATURE <i>H. H. Holston, M.D.</i>		22b. DATE SIGNED <i>12/26/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. H. Holston</i>		22d. ADDRESS <i>7401 Blair Rd NW</i>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12/28/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>BULLARD FAMILY BURYING GROUNDS, NEAR ROSEBORO, CUMBERLAND CO.,</i>	23d. LOCATION (City, town, or county) (State) <i>N.C.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Emmett L. Pomeroy, Inc., Silver Spring, MD.</i>		25a. REC'D BY REGISTRAR <i>DEC 29 '60</i>	25b. REGISTRAR'S SIGNATURE <i>W. S. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14097

CERTIFICATE OF DEATH

Reg. Dist. No. 13993

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8716 EWING DRIVE				d. STREET ADDRESS 1 8716 EWING DRIVE			
3. NAME OF DECEASED (Type or print) First Middle Last ISADOR BURDETT				4. DATE OF DEATH Month Day Year DECEMBER 27, 1960 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 22, 1898		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			10b. KIND OF BUSINESS OR INDUSTRY RUSSIA		11. BIRTHPLACE (State or foreign country) RUSSIA		
13. FATHER'S NAME MENDEL BURDETT			14. MOTHER'S MAIDEN NAME RACHEL LEVIN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT MELVIN BURDETT 4201 MASSACHUSETTS AVE., N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma large bowel							INTERVAL BETWEEN ONSET AND DEATH 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1960, to Dec. 27, 1960, that I last saw the deceased alive on Dec. 27, 1960, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				ADDRESS (Street, city or town, state) 4890 Battery Lane, Bethesda			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut M.D.				DATE SIGNED 12/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-29-60		22c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM-TALMUD TORAH CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS 3501 14th Street, N.W.				24a. REC'D BY REGISTRAR DATE DEC 30 '60		24b. REGISTRAR'S SIGNATURE C. L. S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B. DAVENPORT

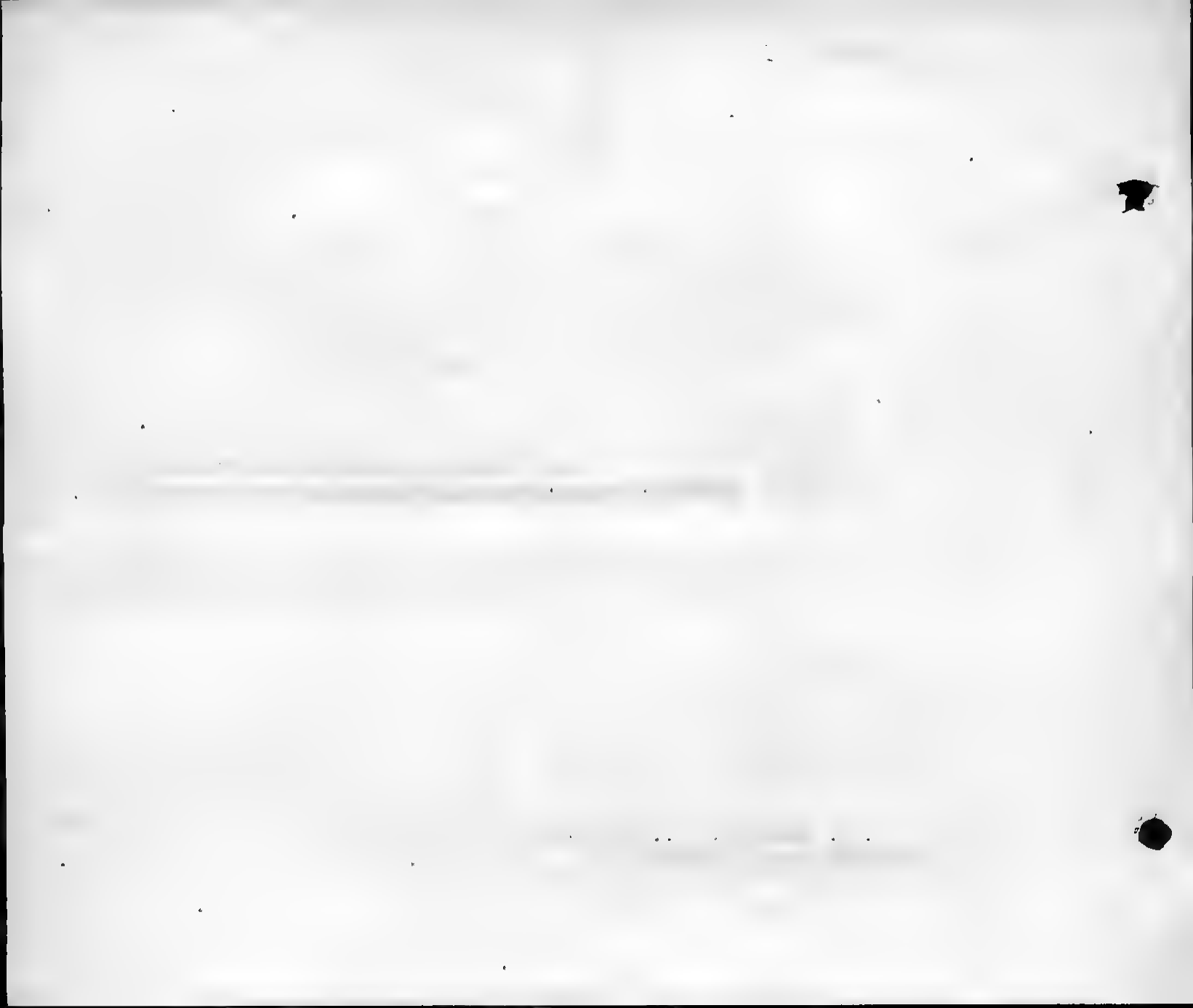
IS-52-60

OHIO 100

14098

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND

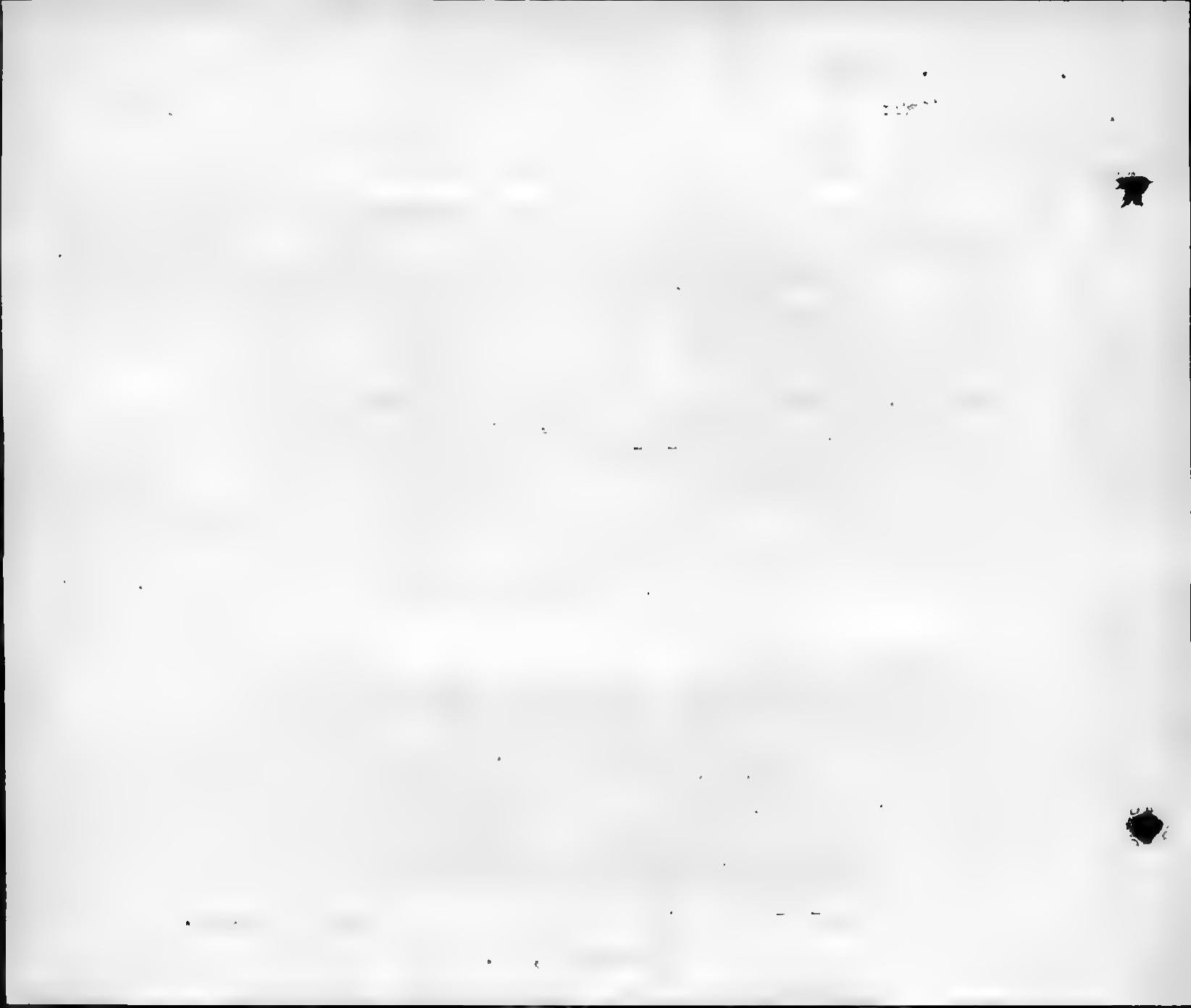
CERTIFICATE OF DEATH

14001

14099

Item 3 File 6277 12-23-60 at

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 20 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington d. STREET ADDRESS 10910 Devin Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Stanley Burroughs		4. DATE OF DEATH Dec. 20 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/20
9. AGE (In years last birthday) 40 yrs.		10. UNDER 1 YEAR Months	11. UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY auto repair	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter M. Burroughs		14. MOTHER'S MAIDEN NAME Mattie Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 216-01-6448	
17. INFORMANT Wife (Alfreda Burroughs)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhages DUE TO (b) Hemorrhagic diathesis DUE TO (c) Acute granulocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 3 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 24, 1960 , to Dec. 20, 1960 , that (I) (we) last saw the deceased alive on Dec. 19, 1960 , and that death occurred at 7 a M, from the causes and on the date stated above.			
22a. SIGNATURE Edward L. McGarry		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. Edward McGarry, M.D.		22d. ADDRESS Suburban Hospital	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-60	
23c. NAME OF CEMETERY OR CREMATORY Brookeville		23d. LOCATION (City town, or county) (State) Brookeville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Barber		25a. REC'D BY REG STRAR DEC 23 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Wm. L. S. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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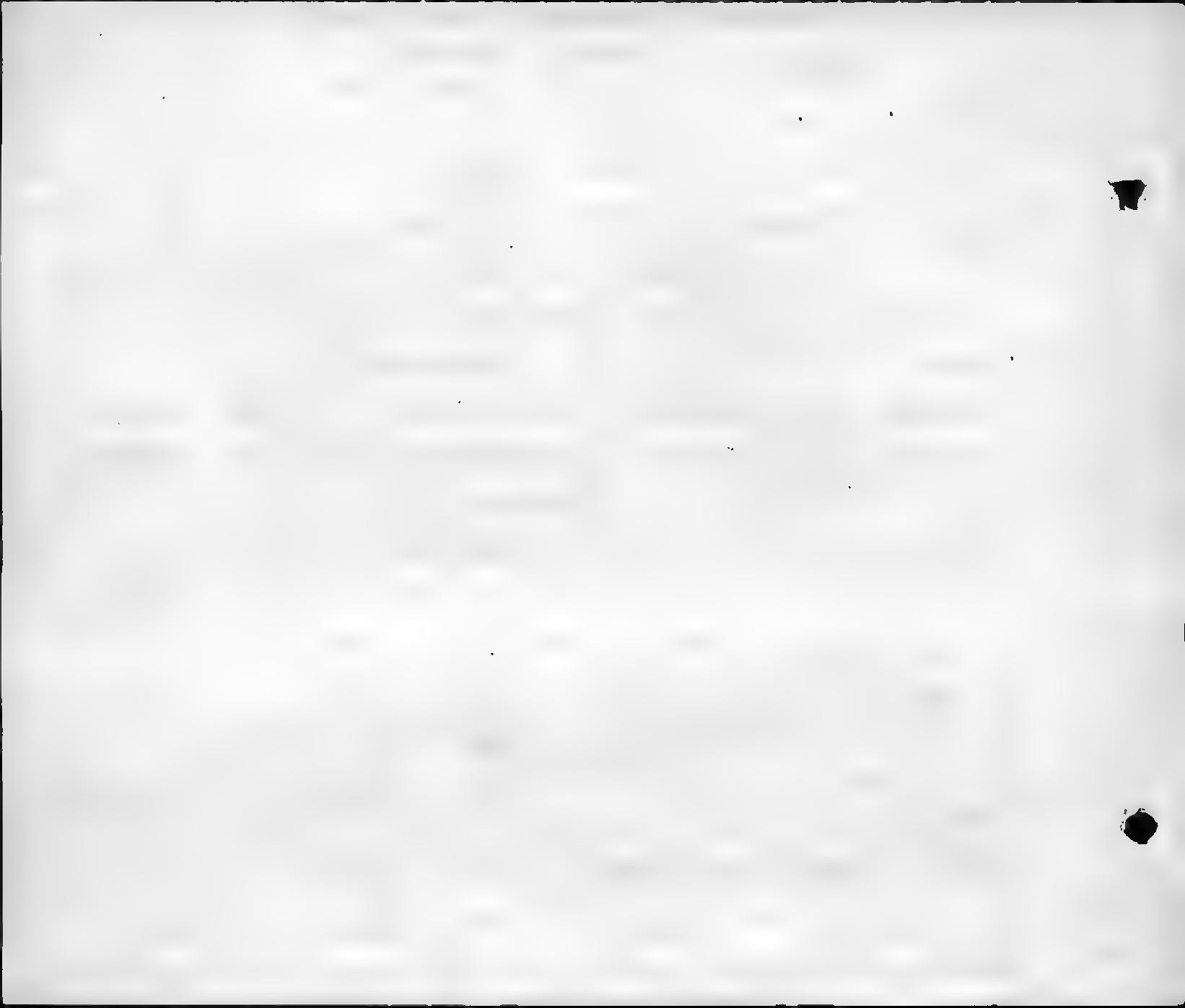
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>District of Columbia</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>12/10/60</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilee Nursing Home</u>		d. STREET ADDRESS <u>1232-Farragut Pl. N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>O.</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Butcher Meats</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret M. Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-07-5989</u>	
17. INFORMANT <u>Virginia M. Butler, wife</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>ARTERIO-SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>41 DAYS</u> <u>10-5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 71</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>55</u> , to <u>Dec 13 1960</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert B. Gray</u> M.D. <u>7105 Ragsdale Rd.</u> PHYSICIAN'S NAME (Type) <u>Robert B. Gray</u> <u>Hypertensive Mid.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) <u>Switzland, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>Mt Rainier Md</u>		24a. REC'D BY REGISTRAR <u>DEC 19 60</u> DATE	24b. REGISTRAR'S SIGNATURE _____



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

<div style="text-align: center;"> <div>14003</div> <div> <div>CERTIFICATE OF DEATH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> </div>											
1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1005 MERRIMAC DRIVE APT. #1						d. STREET ADDRESS 1005 MERRIMAC DRIVE APT. #1				<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO	
3 NAME OF DECEASED (Type or print) PETER (NMI) (PANOS) CAMBAS						4. DATE OF DEATH Month DEC. 15 Day 19 Year 60					
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH JAN. 1, 1886		9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANDY MAKER, RETIRED				10b KIND OF BUSINESS OR INDUSTRY CANDY MANUFACTURING		11. BIRTHPLACE (State or foreign country) SMYRNA, TURKEY			12 CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME DIMITRIOS CAMBAS						14 MOTHER'S MAIDEN NAME FOTINI POLITIS					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)				16 SOCIAL SECURITY NO. 066-09-3345		17 INFORMANT Address IDA G. CAMBAS, 1005 MERRIMAC DRIVE, SILVER SPRG.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation DUE TO (b) Chronic cardiac decompensation Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 wks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month September Day 12 Year 1960 Hour a. m. p. m.				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from September 1960 to December 1960, that (I) (we) last saw the deceased alive on December 12, 1960, and that death occurred at 12:15 PM, from the causes and on the date stated above											
22a SIGNATURE Bennet A. Porter, Jr., M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED December 16, 1960			
22c PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.						22d ADDRESS 4301 Colesville Rd., Silver Spring, Md.					
23a BURIAL, CREMATION OR REMOVAL (Specify) BURIAL				23b DATE THEREOF DEC. 19, 1960		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska						25a REC'D BY REGISTRAR DATE DEC 22 '60		25b REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

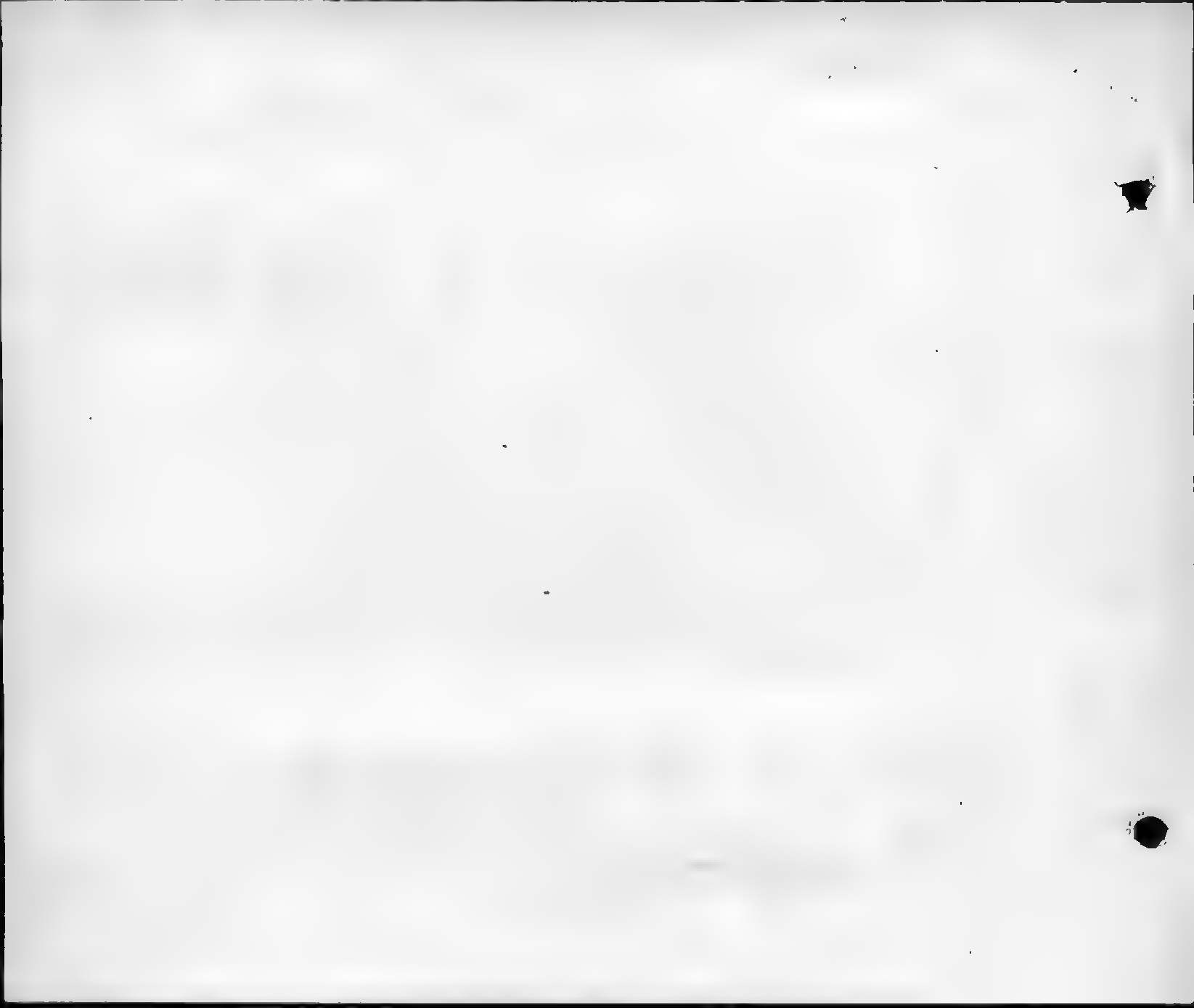
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14100

14004

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>7610 Conn. Ave. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>R</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 8, 1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>same</u>	
13. FATHER'S NAME <u>N. Robertson</u>				14. MOTHER'S MAIDEN NAME <u>Rogers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Clarence E. Carter, husband</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Vascular Disease</u> DUE TO (c) <u>Digitalis Intoxication</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1960</u> to <u>Dec. 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1960</u> , and that death occurred at <u>9:20</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Gene U. Cohen</u>				22b. DATE SIGNED <u>Dec. 31, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Gene U. Cohen</u>				22d. ADDRESS <u>931 P. ...</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>JAN 3 61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

MEDICAL CERTIFICATION



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14023
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 16x-			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>6511 3rd Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BILLY</u> Middle <u>EDWARD</u> Last <u>CAVIN</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 7, 1960</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma Park, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Billy Joe Cavin</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Jane Mays</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Homer M. Cavin, 6615 Brotherhood (TR)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 8</u> 19 <u>60</u> to <u>Dec 9</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>Dec</u> 19 <u>60</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Jacobs</u>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT J. JACOBS</u>				22d. ADDRESS <u>10620 Georgia Ave. Silver Spring MD</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 12, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Fork Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>North Fork Tenn</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur W. ...</u> ADDRESS <u>254 Carroll St NW. DC</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>C. ...</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14006

14101

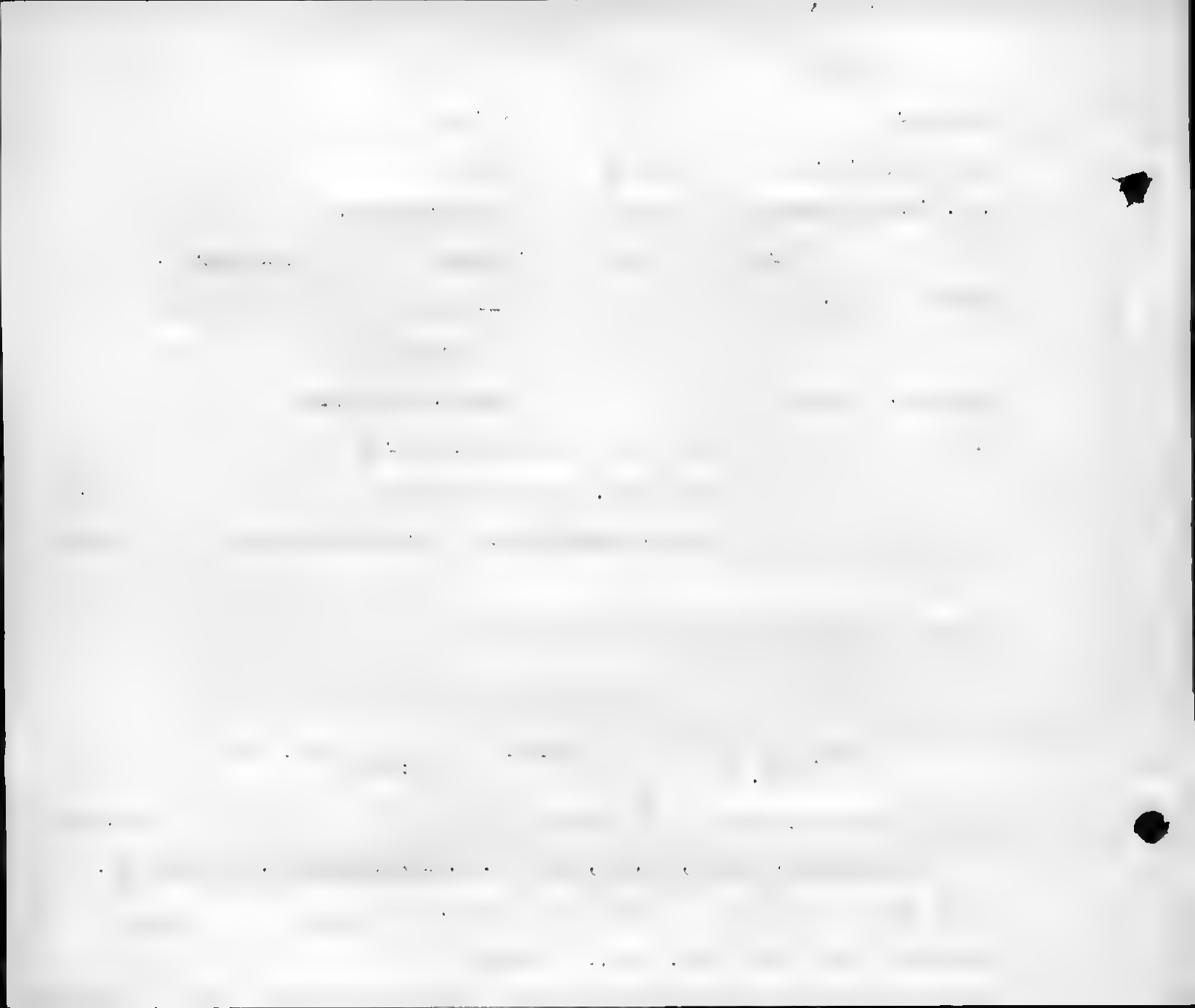
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Hampton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampton d. STREET ADDRESS 13 Mitchell Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Karen Middle Gail Last CHAPMAN				4. DATE OF DEATH Month December Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-10-60	
9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR 4 Months 16 Days		11. IF UNDER 24 HRS 16 Hours 16 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stanley R. CHAPMAN				14. MOTHER'S MAIDEN NAME Ruby G. STRICKLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, organism unknown DUE TO Urinary tract infection, organism unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8 days (c) 8 days INTERVAL BETWEEN ONSET AND DEATH 72 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart disease & convulsive disorder							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Dec. Day 3 Year 1960 Hour 12:50AM a. m. 12:50AM p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Norfolk (County) Virginia (State)			
21. I certify that (I) the hospital attended the deceased from Dec. 3 1960 to Dec. 26 1960 , that (I) the last saw the deceased alive on Dec. 26 1960 , and that death occurred at 12:50AM M, from the causes and on the date stated above.							
22a. SIGNATURE Lawrence G. Thorne				22b. DATE SIGNED 12-26-60			
22c. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Shipment 12-27-60		23b. DATE THEREOF 12-27-60		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d. LOCATION (City, town, or county) Norfolk Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS Lee Funeral Home, 4th & Mass. Aves., NW, WashDC				25a. REC'D BY REGISTRAR DEC 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

MEDICAL CERTIFICATION

05

I

Now



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

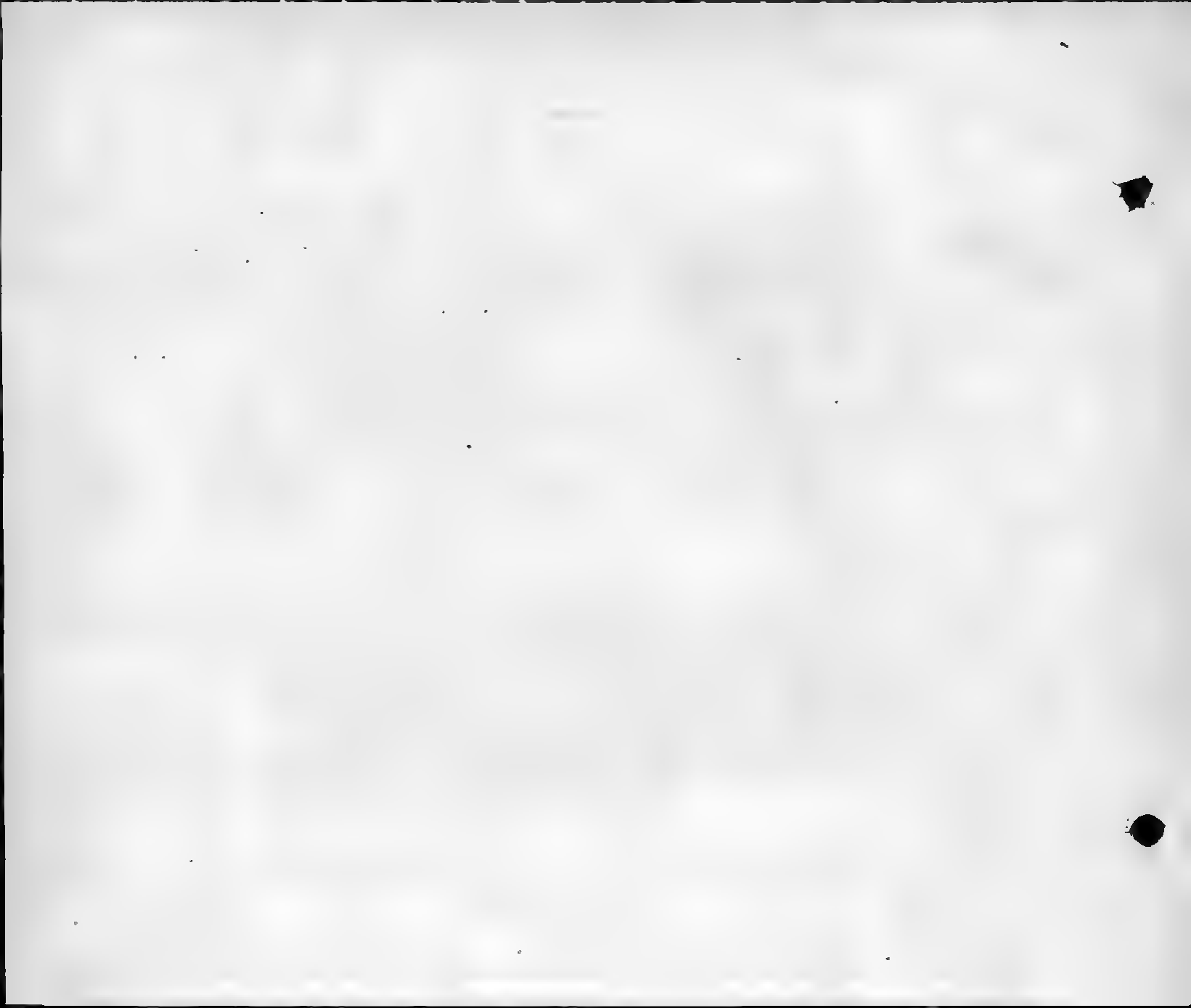
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14007

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 715 Kennebec Ave.		e. STREET ADDRESS 715 Kennebec Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH H. CHAPPELL		4. DATE OF DEATH Month Day Year Dec. 25, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rehabilitation Spec.		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles M. Chappell		14. MOTHER'S MAIDEN NAME Leda Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son Paul H. Chappell		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED Dec. 26, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE DEC 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

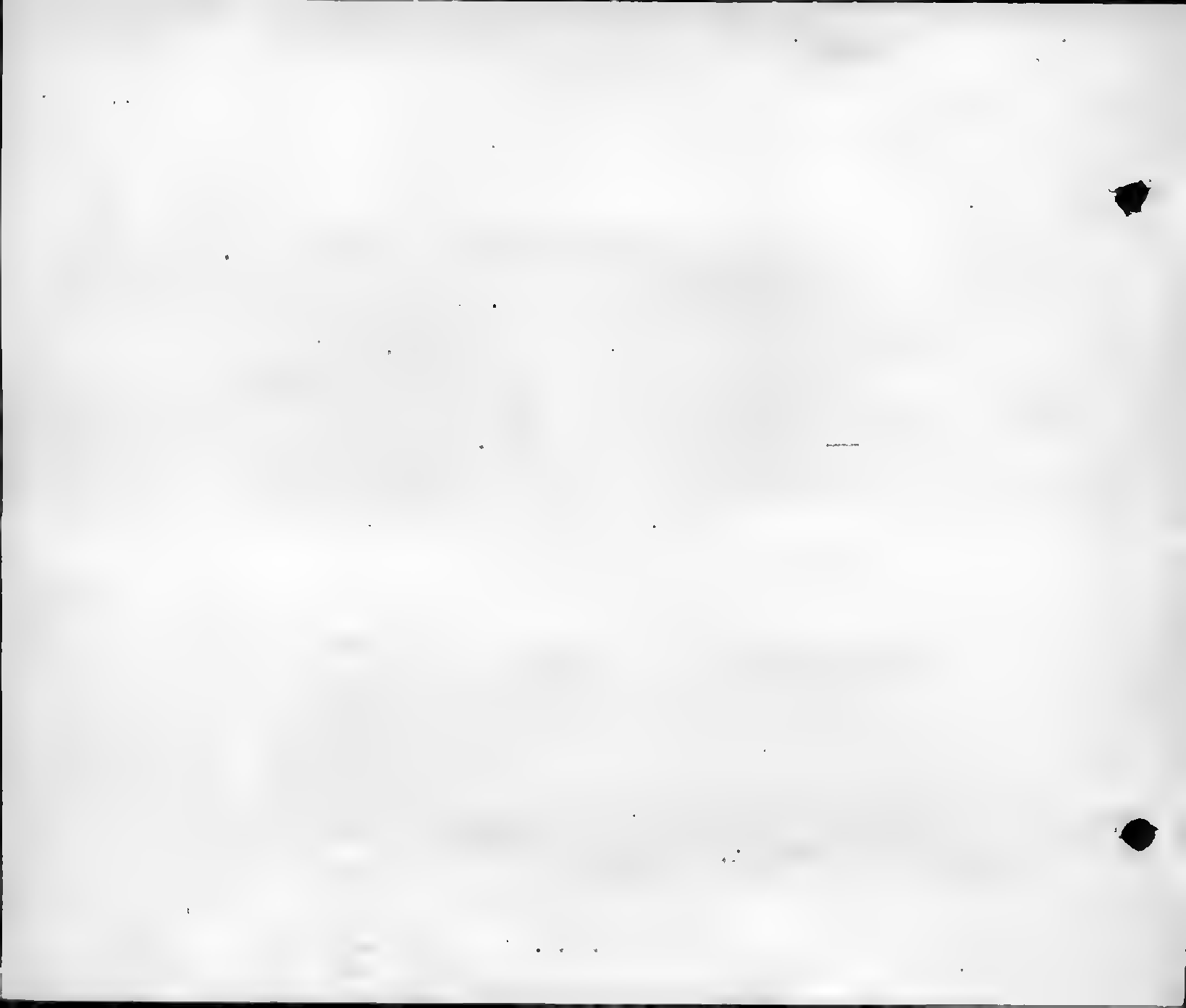
VR A15 (4)
15M 9/59

14064

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14008

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4605 DRUMMOND AVENUE		d. STREET ADDRESS 4605 DRUMMOND AVENUE	
3. NAME OF DECEASED (Type or print) First MARY Middle FAULDS Last CHRISTOPHER		4. DATE OF DEATH Month DEC. 22 Day 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1878
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) LIVERPOOL, ENGLAND		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME THOMAS FAULDS		14. MOTHER'S MAIDEN NAME ALICE McCOMESKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO ---	
17. INFORMANT MARY C. LETHERIDGE, SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-0 DUE TO coronary occlusion. Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1959, to Dec. 22, 1960, that (I) (we) last saw the deceased alive on Dec. 2, 1960, and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas L. Hartman		22b. DATE SIGNED DEC 27 1960	
22c. PHYSICIAN'S NAME (Type) THOMAS L. HARTMAN		22d. ADDRESS 1834 Ego Ave. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/26/60	
23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		23d. LOCATION (City, town or county) (State) RACINE, WISCONSIN	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulino		25a. REC'D BY REGISTRAR DATE DEC 27 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

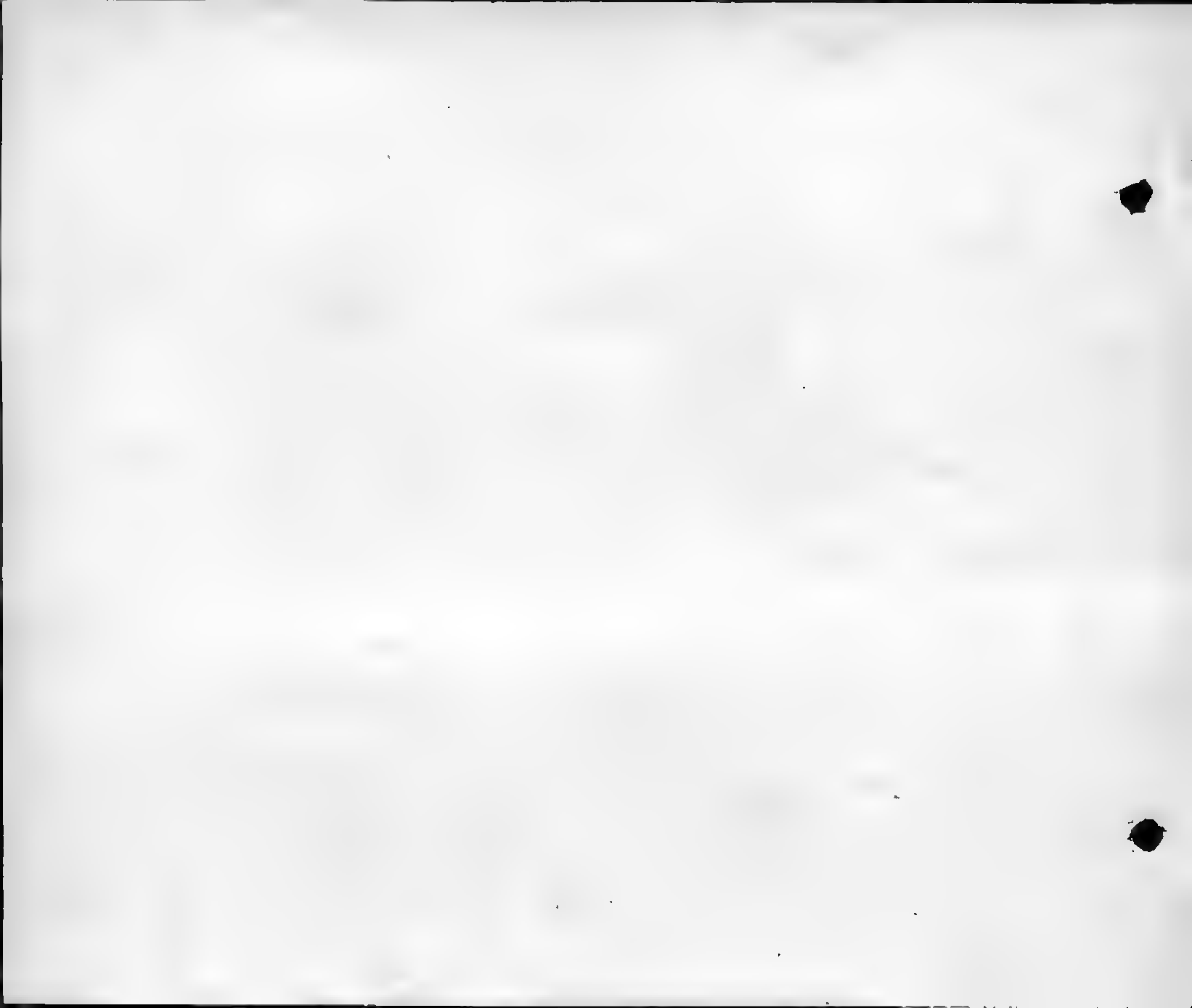
14025

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> <u>37X-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>	
c. LENGTH OF STAY IN 1b <u>53 days</u>		d. STREET ADDRESS <u>1763 Columbia Rd N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucienne</u> Middle <u>Margaret</u> Last <u>Clarke</u>		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Dance school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Europe</u>	
11. BIRTHPLACE (State or foreign country) <u>Europe</u>		12. CITIZEN OF WHAT COUNTRY? <u>America-USA.</u>	
13. FATHER'S NAME <u>Lucian Bernhard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret F. L. R. Heinemann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Washington San & Hosp. Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chorea, left Temporo-parietal</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Dec 9, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 9, 1960</u> , and that death occurred at <u>12 M</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John T. Lord</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord</u>		22d. ADDRESS <u>1015 Spring St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Dec 10, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Baker</u>		25a. REC'D BY REGISTRAR <u>DEC 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION



14080

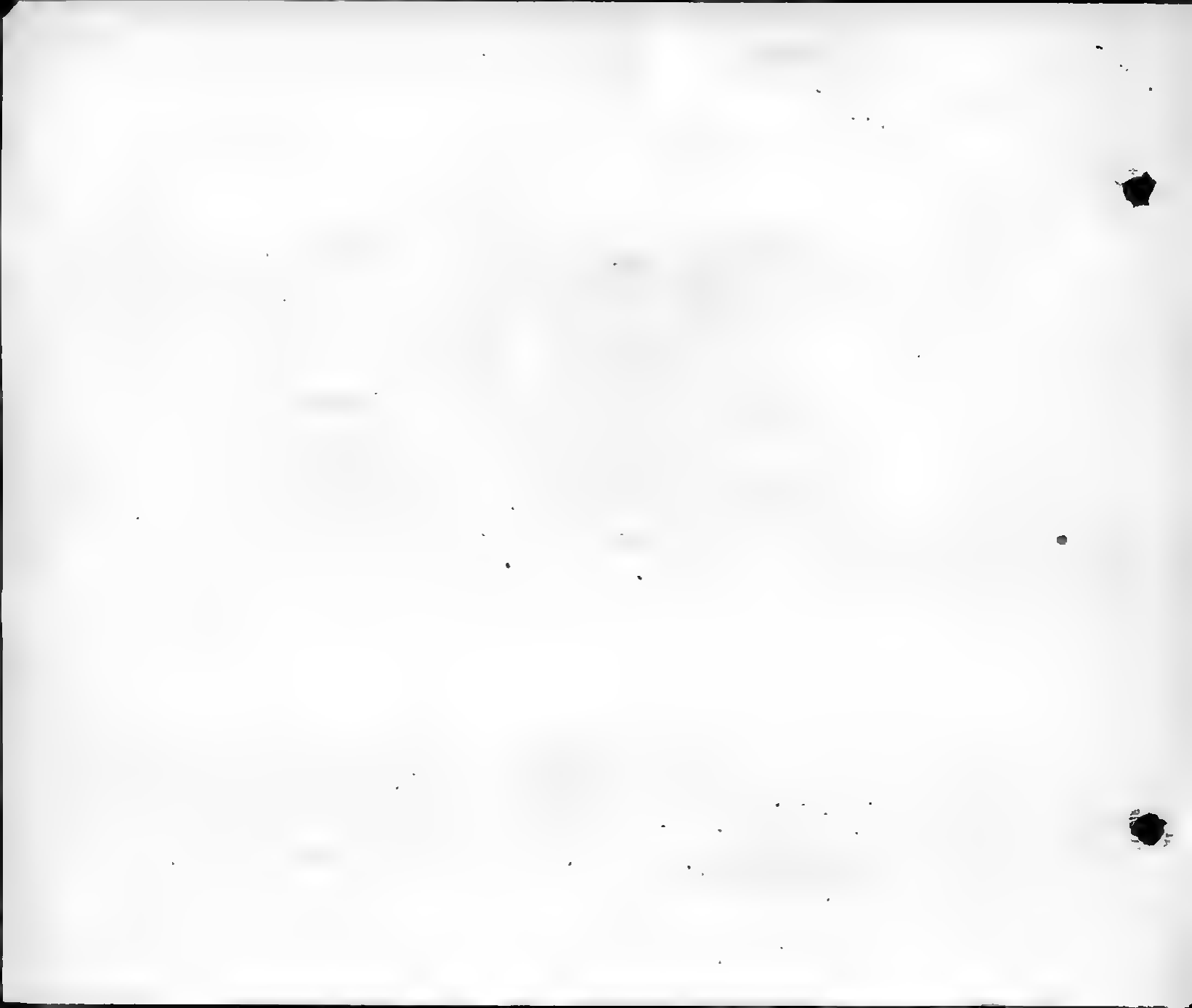
CERTIFICATE OF DEATH

Reg. Dist. No.

14010

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 Blandford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NOAH EDWARD CLEM		4. DATE OF DEATH Month Day Year DEC. 10 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/02
9. AGE (In years lost b'rthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY WHEATON HIGH	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ADDISON ELMORE CLEM		14. MOTHER'S MAIDEN NAME ANNA ELIZ. LLOYD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO WIFE (SAME AS ABOVE)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid, Myocardial Infarction 422-1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Acute Acute Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1/1960 to 12/10/1960 , that I last saw the deceased alive on 12/10/1960 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 503 Viers Mill Road, Rockville, Md. DATE SIGNED 12/10/60			
ACTUAL SIGNATURE Stephen N. Jones M.D.		PHYSICIAN'S NAME (Type) STEPHEN N. JONES	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/60	
22c. NAME OF CEMETERY OR CREMATORY Jacksonville		22d. LOCATION (City, town, or county) (State) Floyd, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home ADDRESS 1331 E. Montgomery, ve., Rockville, Md.		24a. REC'D BY REGISTRAR DATE DEC 13 '60	
24b. REGISTRAR'S SIGNATURE William S. Kline			

TO HOSPITAL ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14102

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14011

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 64 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1363 Peabody Street, N.W. Apt. 204 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Louis Middle (None) Last Cohn			4. DATE OF DEATH Month December Day 4 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1895	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Nebraska	
13. FATHER'S NAME Morris Cohn			14. MOTHER'S MAIDEN NAME Bluma (Unknown) Hilda		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 347-07-9134		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clostridium Septicemia 572.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Regional Enteritis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Unknown 15 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1, 19 60 to December 4, 19 60 , that I last saw the deceased alive on December 4, 19 60 , and that death occurred at 5:41 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-5-60 ACTUAL SIGNATURE Orlando W. McBride M.D. National Institutes of Health PHYSICIAN'S NAME (Type) ORLANDO W. McBRIDE, M.D. Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
				22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th - NW			24a. REC'D BY REGISTRAR DATE DEC 9 '60		24b. REGISTRAR'S SIGNATURE 118

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



1
 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

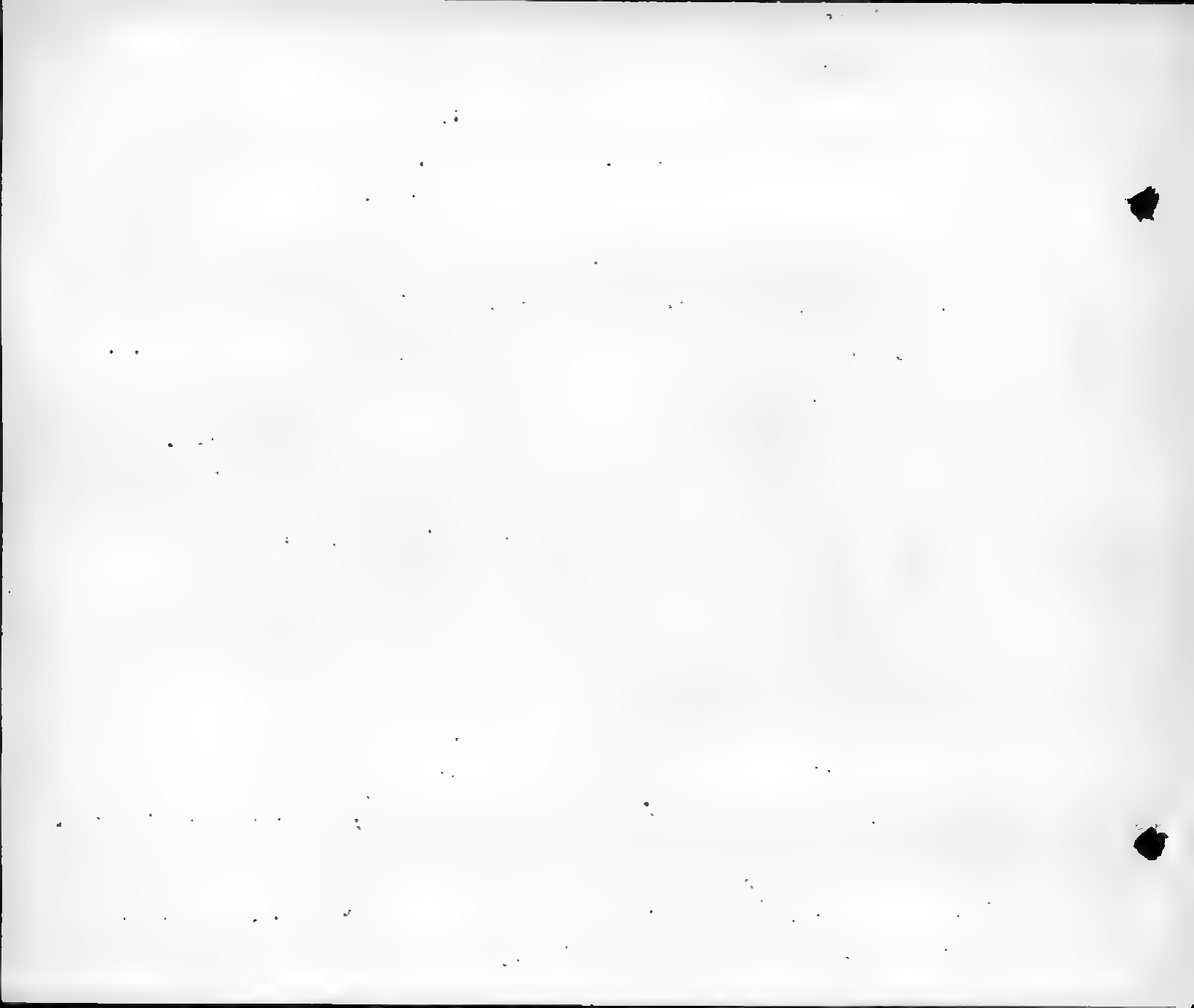
14103

CERTIFICATE OF DEATH

Reg. Dist. No.

14012

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Augusta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u>		c. LENGTH OF STAY IN 1b <u>2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>309 Betsybell</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>C.</u> Last <u>Cook</u>		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11 1876</u>
9. AGE (In years lost birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Nicowander</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Frank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Nellie Wiseman</u>		Address <u>Dickerson Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2, 1960</u> to <u>Dec 17, 1960</u> that I last saw the deceased alive on <u>Dec 16, 1960</u> and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vernon E. Hartens</u> M.D.		ADDRESS (Street, city or town, state) <u>German town, Md.</u> DATE SIGNED <u>Dec 17, 60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Thornrose</u>	22d. LOCATION (City, town, or county) (State) <u>Staunton Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		ADDRESS <u>Baunerville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneer</u>	



14004

CERTIFICATE OF DEATH

14013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before adm'ss on) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 6007 43 rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHRISTAINA ROBB CROMAR		First		Middle		Last		4. DATE OF DEATH Month 20 Day 25 Year 1960		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 2, 1867		9. AGE (in years lost birthday) 93 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Robb	
14. MOTHER'S MAIDEN NAME Ann Spence		15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO non		17. INFORMANT Mrs Marian C. Herr- Daughter- same as # 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 422.21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 week		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month Day Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9-20-1960 to 12-25-1960 that I last saw the deceased alive on Jan 18, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John Rogers MD 1919 Annapolis Rd 12-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) Annapolis, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR DEC 28 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14104

14014

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 1304 8th Avenue			
3. NAME OF DECEASED (Type or print) First William Middle Earl Last Crowgey				4. DATE OF DEATH Month December Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1949	
9. AGE (In years last birthday) 11 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Crowgey				14. MOTHER'S MAIDEN NAME Betty Lindamood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyperuricemia DUE TO (c) Acute Lymphatic Leukemia						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 Week 2 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 19, 19 60 , to December 29, 19 60 , that I last saw the deceased alive on December 29, 19 60 , and that death occurred at 7:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. Walter Oppelt</i>				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.				DATE SIGNED 12-29-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-29-60				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	
22d. LOCATION (City, town, or county)				22e. (State)		22f. (County)	
22g. (City, town, or county)				22h. (State)		22i. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 3 '61	
24b. REGISTRAR'S SIGNATURE <i>Carlton L. Hume</i>				24c. (City, town, or county)			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

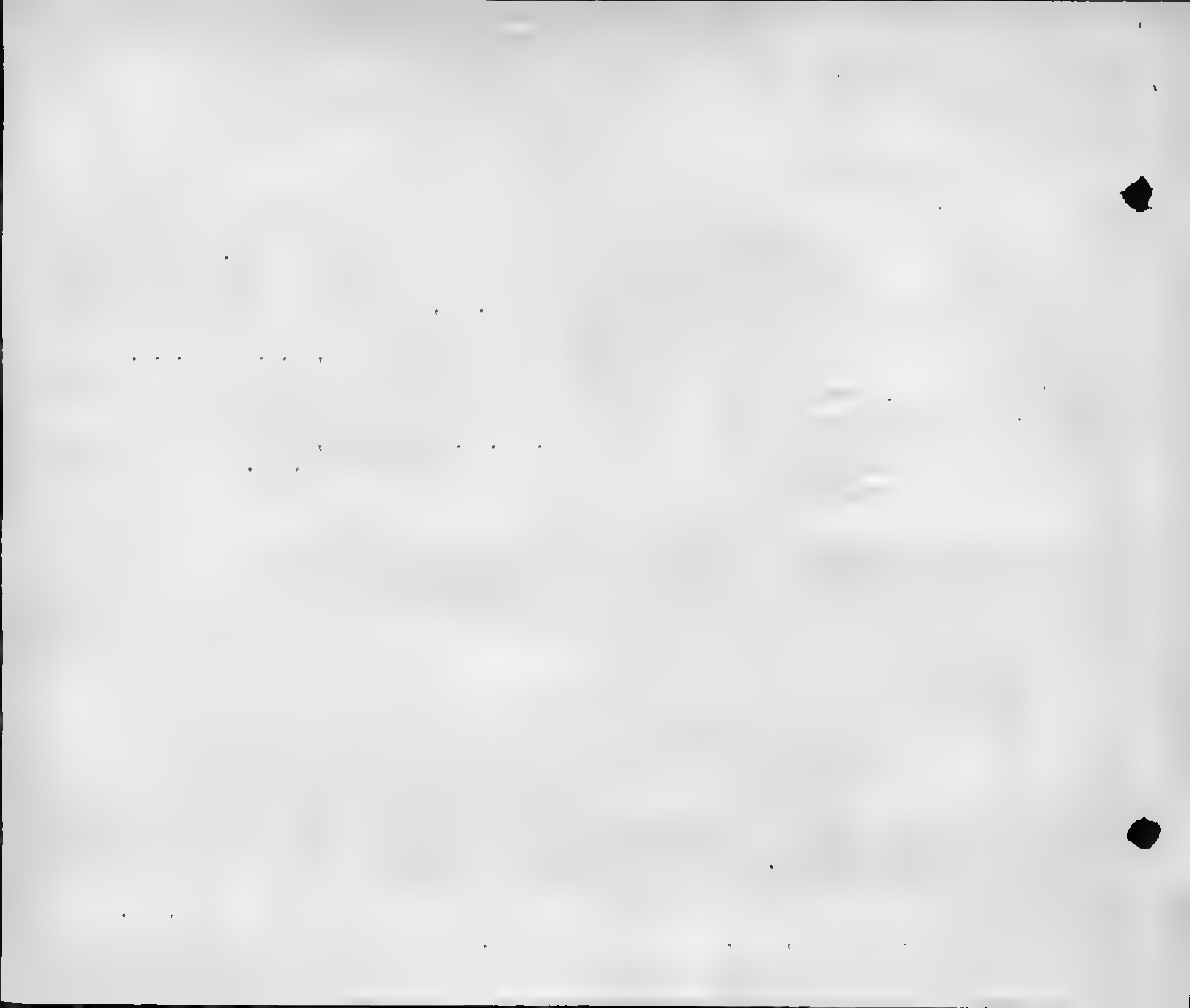
1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14005
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14015

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2626 CORY TERRACE		d. STREET ADDRESS 2626 CORY TERRACE	
3. NAME OF DECEASED (Type or print) MARJORIE		4. DATE OF DEATH DEC. 11 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 26, 1960	
9. AGE (In years, last birthday) yrs. 2 Months 15		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. CUNNINGHAM		14. MOTHER'S MAIDEN NAME MARY VIRGINIA EUBANKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Wm. J. Cunningham, 2626 Cory Terrace Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475X DUE TO Asphyxia (b) Upper Respiratory Infection (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/13/60	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE DEC 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14105 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

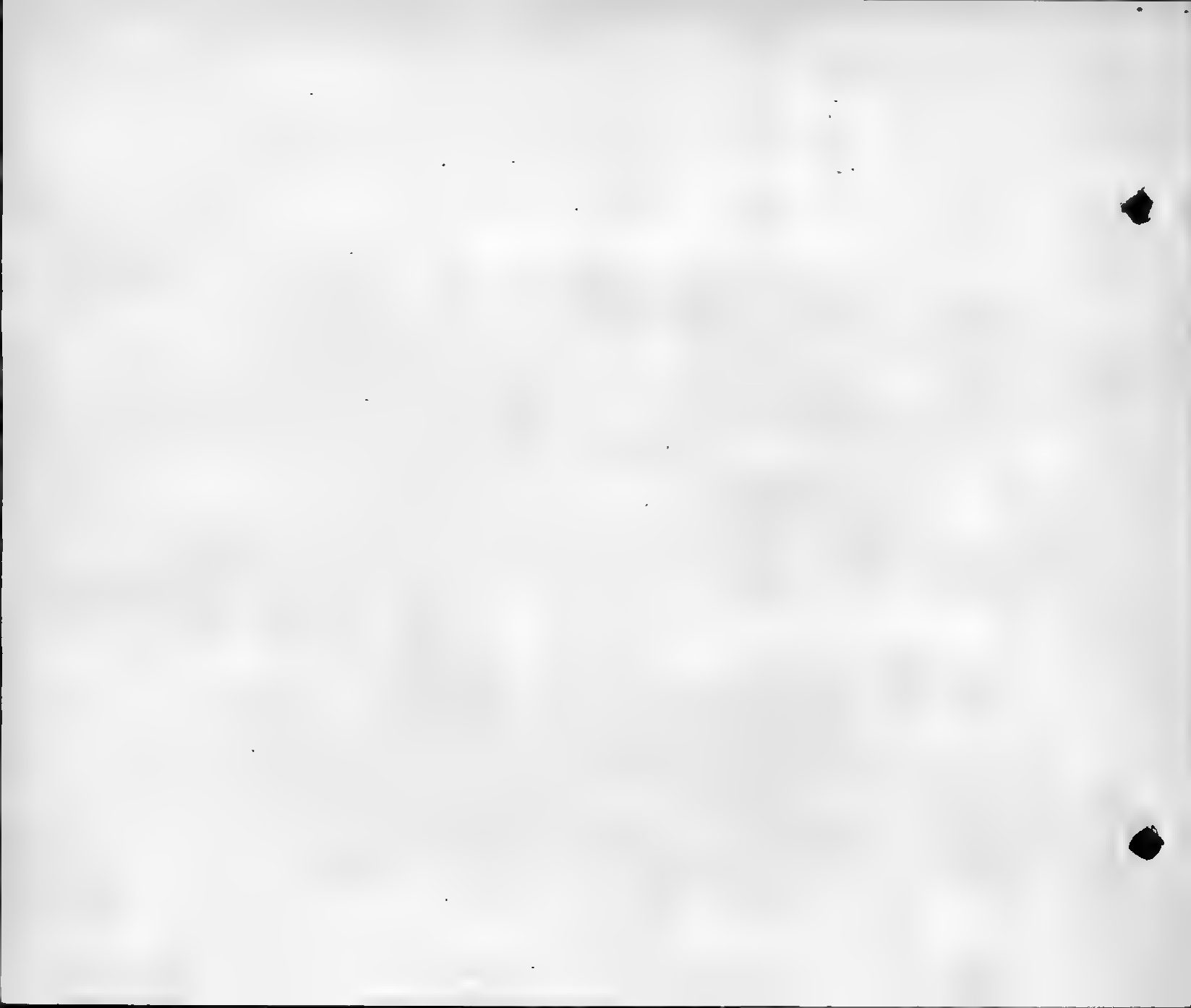
Reg. Dist. No.

14016

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Building #30 Nat. I. Health</u>		d. STREET ADDRESS <u>110225- Douglas Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Cunningham</u>		4. DATE OF DEATH <u>Dec 13 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-05</u>
9. AGE (in years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>60</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chumner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DE</u>	
11. BIRTHPLACE (State or foreign country) <u>DE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Barry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>578-07-3700</u>	
17. INFORMANT <u>Mrs. Elaine Cunningham (wife)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while working on a construction job</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month <u>12</u> Day <u>13</u> Year <u>1960</u> Hour <u>—</u> a. m. <u>—</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-13-60</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12-16-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Koolhuis</u> ADDRESS <u>3821-14th St. N.W., Wash, D.C.</u> 24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>			

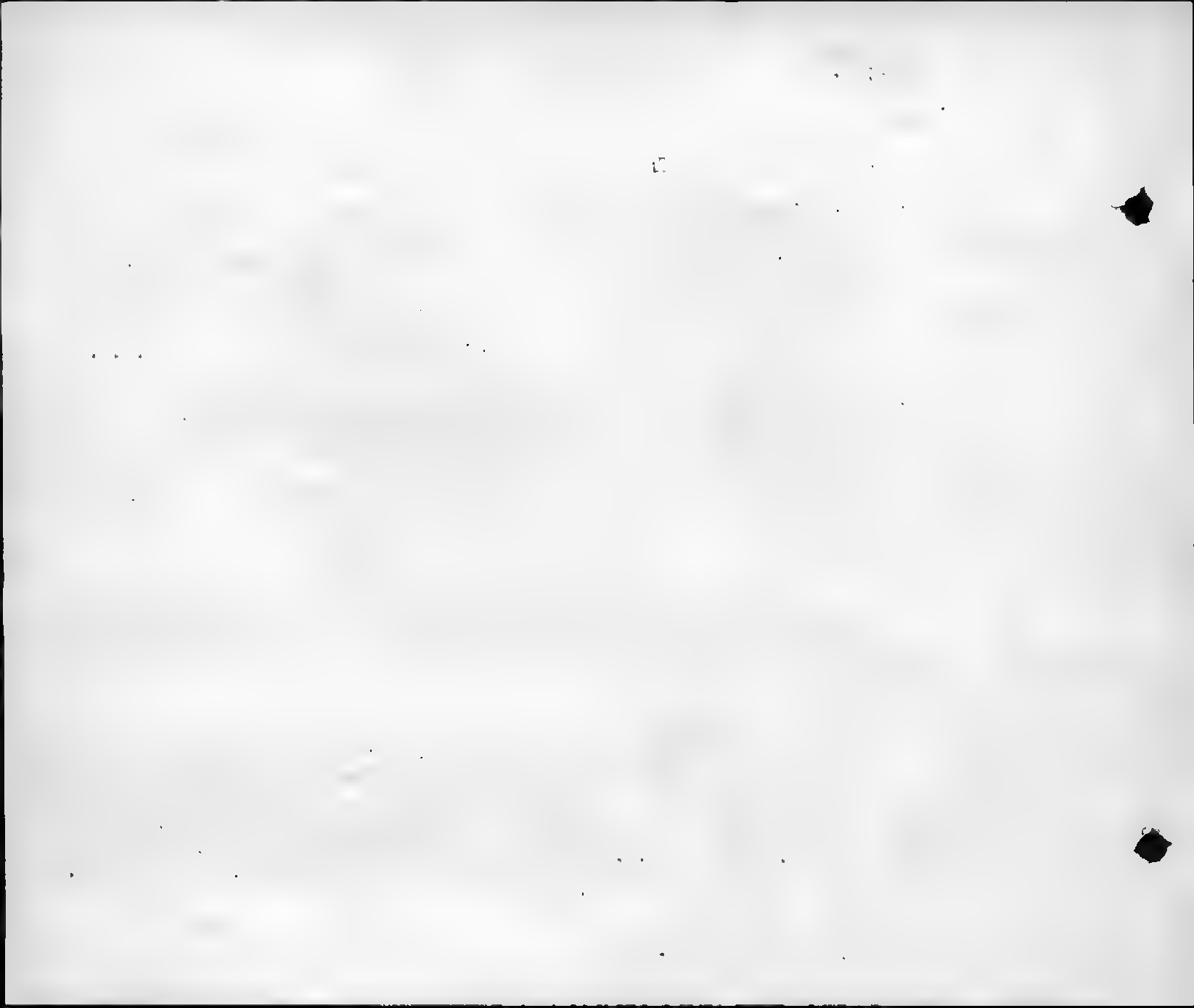
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14106
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14017

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 9409 Colesville Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Grace Middle (None) B. Last Curran				4. DATE OF DEATH Month December Day 16 Year 19 60			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 19, 1880	9 AGE (in years last birthday) 80 yrs	10 UNDER 1 YEAR Months Days Hours Min. 		11 UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Wisconsin		12 C. TIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Baker				14. MOTHER'S MAIDEN NAME Eulalia Alling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, The Clinical Center Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Heart Disease. 112000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 5, 19 60 to December 16, 19 60 that (I) (we) last saw the deceased alive on December 16, 19 60 , and that death occurred at 1:30 PM from the causes and on the date stated above							
22a. SIGNATURE Thomas E. Gaffney				22b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
22c. PHYSICIAN'S NAME (Type) Thomas E. Gaffney M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Walter Walters				25a. REC'D BY REGISTRAR DEC 21 '60		25b. REGISTRAR'S SIGNATURE J. E. Kane	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

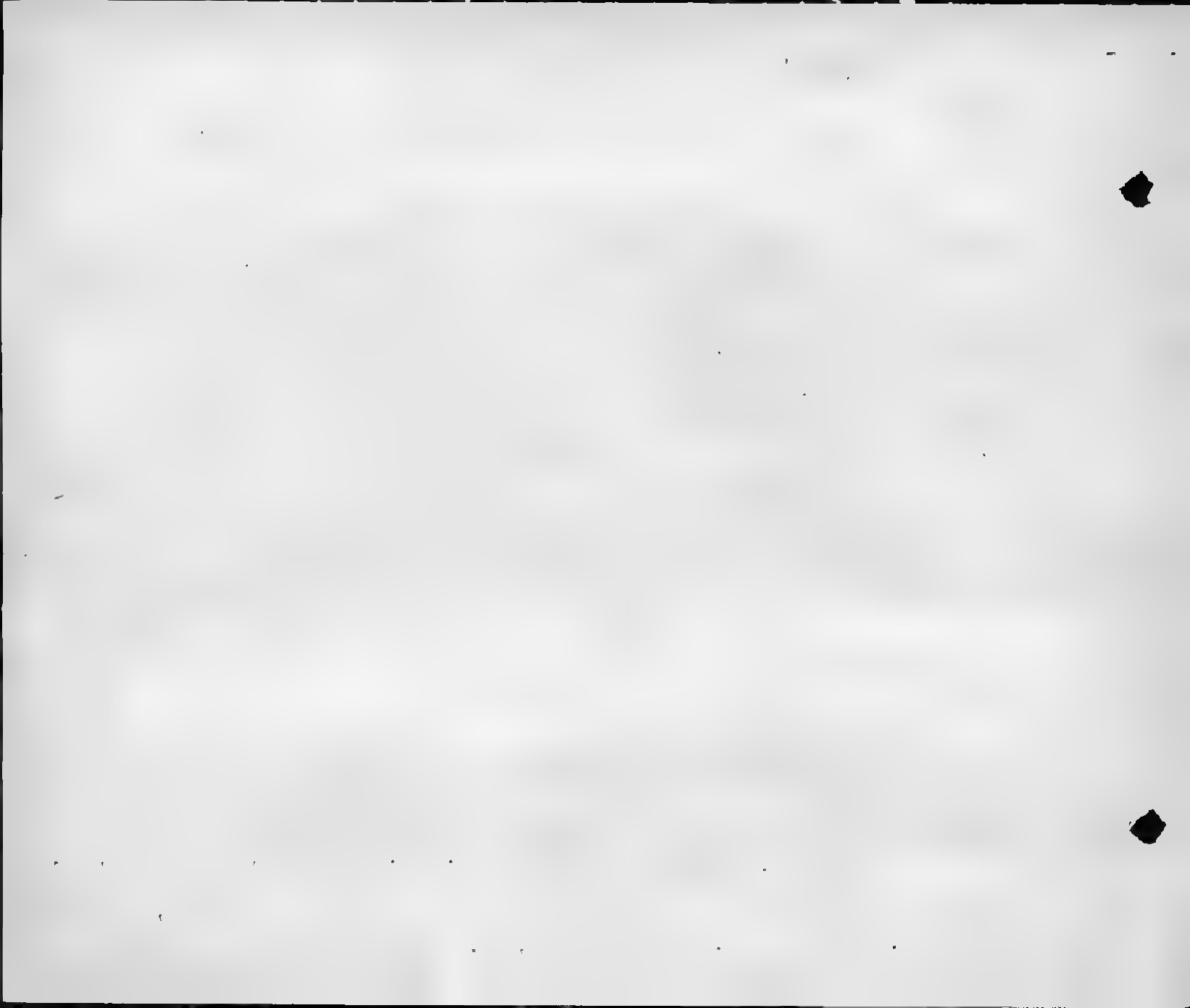
14026

CERTIFICATE OF DEATH

14018

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10205 Southmoor Dr.</u>								
3. NAME OF DECEASED (Type or print) <u>Wanda Marie Dahowski</u>		4. DATE OF DEATH Year <u>1960</u> Month <u>Dec.</u> Day <u>20</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
8. DATE OF BIRTH <u>7-13-12</u>		9. AGE (In years last birthday) <u>48</u> yrs <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min	10. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months Days	Hours Min											
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>								
13. FATHER'S NAME <u>Richard C'Donoghue</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blanche MacWilliams</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>U.S. Hosp. Records</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Hemorrhage</u> <u>331X</u> DUE TO </td> <td rowspan="3" style="vertical-align: middle; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Unknown</u> </td> </tr> <tr> <td colspan="2"> CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Hypertension</u> DUE TO </td> </tr> <tr> <td colspan="2"> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Hemorrhage</u> <u>331X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Unknown</u>	CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Hypertension</u> DUE TO		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident - Hemorrhage</u> <u>331X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Unknown</u>										
CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Hypertension</u> DUE TO												
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)												
20c. TIME OF INJURY Month, Day, Year <u>12-20-60</u> Hour a.m. <u>9:50 AM</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								
20f. (City or town)		20g. (County)		20h. (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>12-20-60</u> to <u>12-20-60</u>, 19<u>60</u>, that (I) (we) last saw the deceased alive on <u>12-20-60</u>, 19<u>60</u>, and that death occurred at <u>9:50 AM</u>, from the causes and on the date stated above.												
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>12-20-60</u>		22c. PHYSICIAN'S NAME (Type, <u>STUART L. NELSON</u>)								
22d. ADDRESS <u>Wash. San. & Hospital, Takoma Park, Md.</u>		22e. REC'D BY REGISTRAR <u>DEC 27 '60</u>										
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>										
23b. DATE THEREOF <u>12/23/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town or county) <u>MONTGOMERY COUNTY, MARYLAND</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>												
25. ADDRESS <u>SILVER SPRING, MD.</u>												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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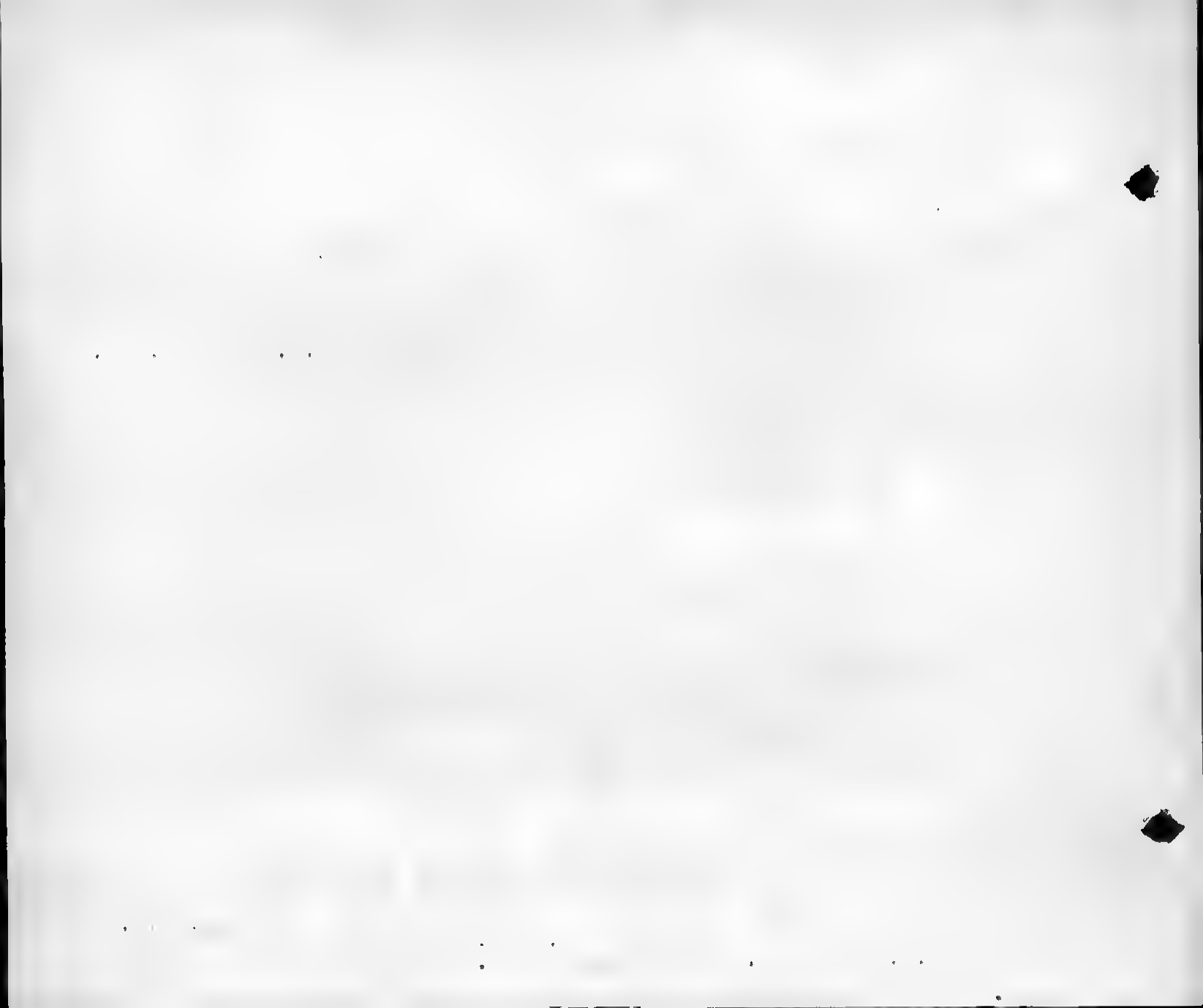
VR A15 (4)
15M 9/59

14027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14019

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 167 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY College Park e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Reta May Dalziel				4. DATE OF DEATH Month Day Year December 2, 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/85	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.	F UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Atkinson			14. MOTHER'S MAIDEN NAME Millie Day				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral vascular accident - hemorrhagic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized hypertensive cardiovascular DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1 Sept 1960 to 2 Dec 1960 , that (I) (we) last saw the deceased alive on 2 Dec 1960 and that death occurred at 9:15 A.M. from the causes and on the date stated above							
22a. SIGNATURE Ernest F. Harmon		M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Ernest F. Harmon M.D.		22d. ADDRESS 9301 Colesville Rd. S.W. S.W. D.C.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) burial	23b. DATE THEREOF 12/5/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W.		25a. REC'D BY REGISTRAR DEC 5 '60		25b. REGISTRAR'S SIGNATURE C. J. Hines	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11020

14006

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>4 months</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>735 Sligo Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First <u>Dangiger</u> Middle <u>Dangiger</u> Last		4. DATE OF DEATH <u>December 11</u> Month <u>11</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/5/06</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> Hours <u></u> Min <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Morris Seif</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Frank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-48-0875</u>	
17. INFORMANT <u>Henry Armin Dangiger - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition & Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Carcinomatosis</u> DUE TO (b) <u>1 month</u> DUE TO (c) <u>2 months</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>10/26</u> 19 <u>60</u> , to <u>12/11</u> 19 <u>60</u> , that (I) <u>no</u> last saw the deceased alive on <u>12/19</u> 19 <u>60</u> , and that death occurred at <u>5</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Armon A. Cairo</u>		22b. ADDRESS <u>Georgetown Univ. Hosp. - Wash. D.C.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Armon A. Cairo</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC 13, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		23d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dangiger & Sons</u>		25a. REC'D BY REGISTRAR <u>3501-14 St. NW</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>DEC 14 '60</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

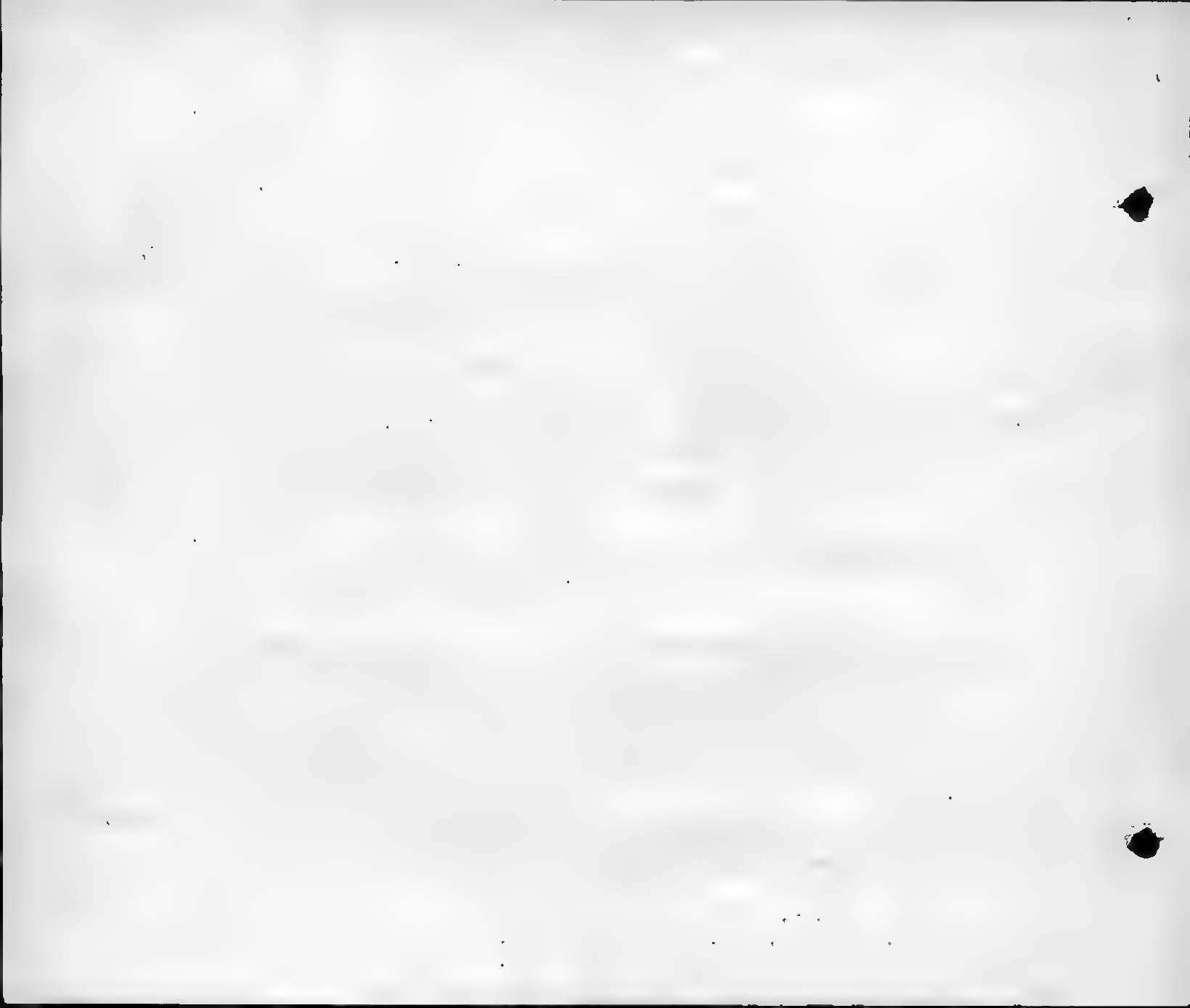
VR A15 (4)
 15M 9/59

14107

14021

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 9107 Louis Ave	
3. NAME OF DECEASED (Type or print) First Ruth Middle Marcella Last DAVIES		4. DATE OF DEATH Month Dec Day 4 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1900
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George G. Simonds		14. MOTHER'S MAIDEN NAME MINNIE Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Husband		Address Carnell Warren DAVIES (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteri Myocardial Infarction DUE TO 3 hr. Conditions if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO 1 yr. (c) Generalized Arteriosclerosis ?		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 17, 1960 to Dec 4, 1960 , that (I) (we) last saw the deceased alive on Dec 2, 1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE George Sharpe		22b. DATE SIGNED Dec 4 1960	
22c. PHYSICIAN'S NAME (Type) George Sharpe		22d. ADDRESS 10511 Summit Ave, Kensington, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		25. REC'D BY REGISTRAR DEC 8 '60	
25a. ADDRESS 8454 GEORGIA AVE. SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Charles L. House	



CERTIFICATE OF DEATH

Reg. Dist. No.

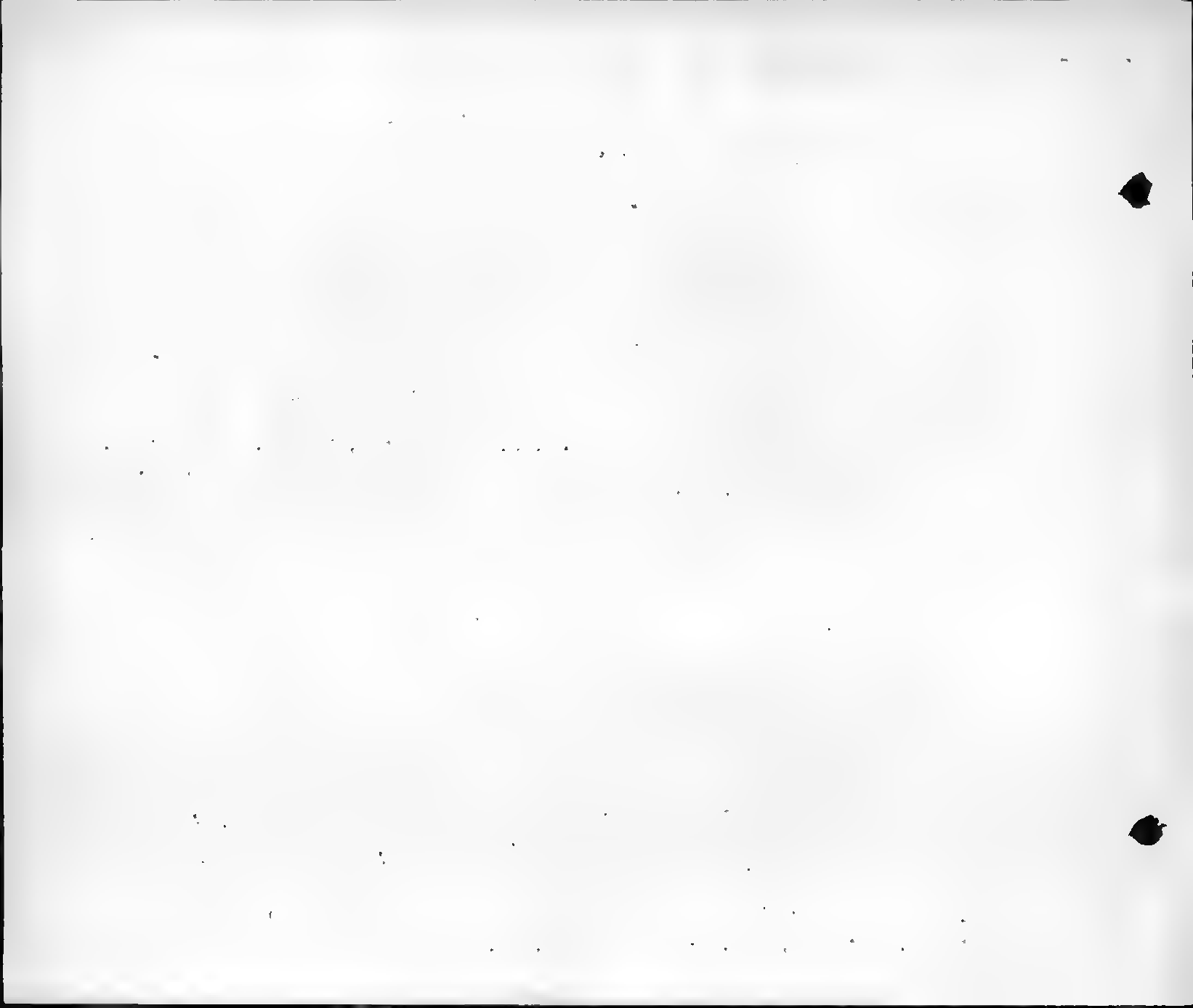
14022

14028

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & Hosp.</u>		d. STREET ADDRESS <u>405 ST. LAWRENCE DR.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Margaret Davis</u>		4. DATE OF DEATH Month Day Year <u>12 12 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-73</u>
9. AGE (In years last birthday) <u>87 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>TENN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>JAMES H. JULIAN</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET GAMBLE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mr. C. Edwin Davis, 405 St. Lawrence Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 422.1 DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>20 yrs</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Right Ribs 3-4-5-6-7.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>60</u> , to <u>Dec 12, 1960</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>60</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George B. Patrick Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9221 Collesville Rd.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>George B. Patrick Jr. MD</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WARRENTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WARRENTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 1960</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11023

1
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4025 Plyers Mill Rd</u>		e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susie Davis</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15, 1890</u>		9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Lydia Thomas</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Daughter Same as Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u>							<u>2 days</u>
DUE TO (b) <u>Cerebral Vascular Accident</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes 7 yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION REMOVAL <input checked="" type="checkbox"/>		22b. DATE THEREOF <u>12/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Landover, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Browder</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14109

CERTIFICATE OF DEATH

Reg. Dist. No.

14024

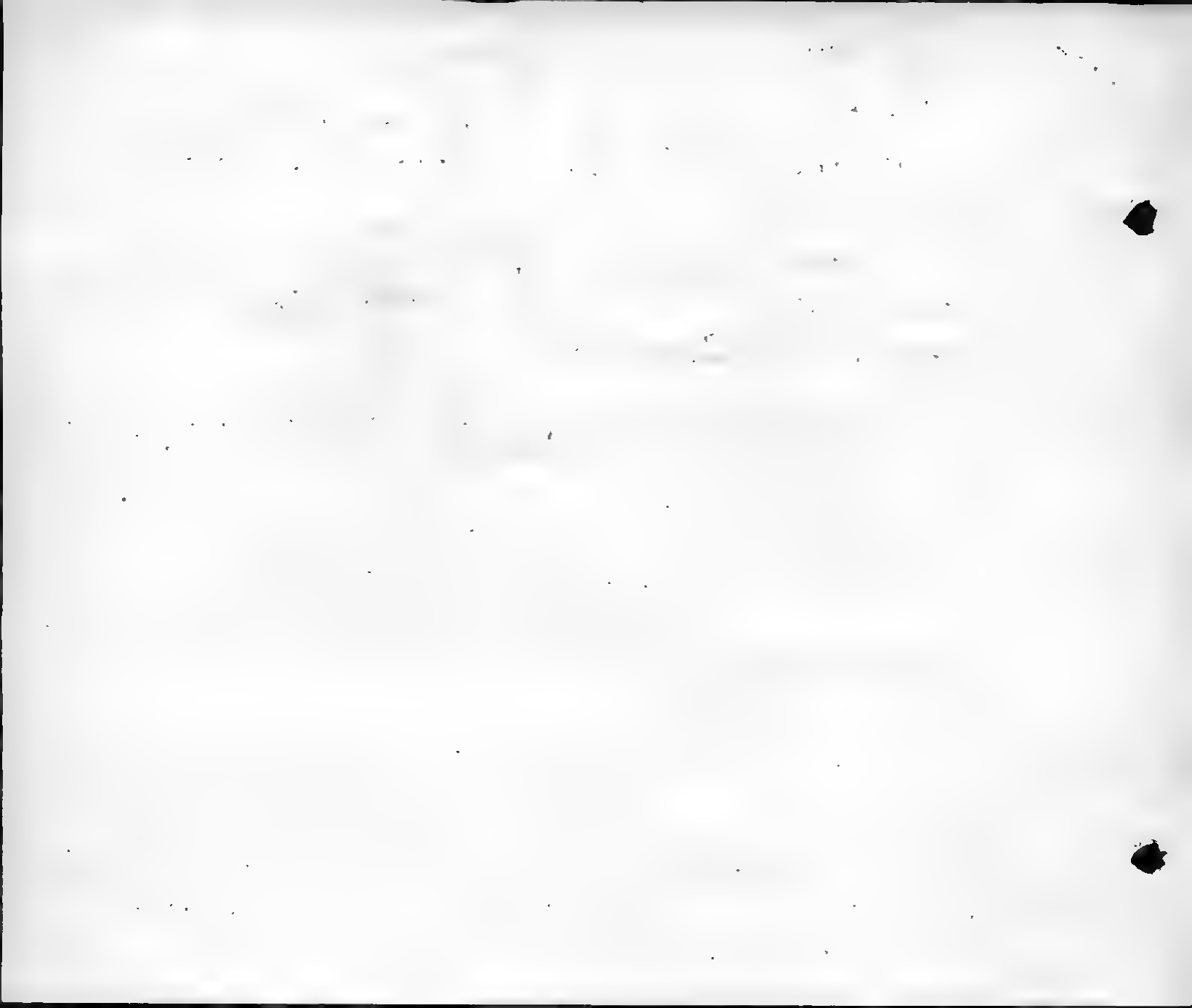
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda. Rt 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS O DAY</u>				4. DATE OF DEATH Month Day Year <u>12 / 3 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James W. Day</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		INFORMANT <u>4512 Great Oak Rd. Rockville, Md.</u>			
				<u>daughter in law - Mrs. F. O Day Jr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>under</u> <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2/1951</u> to <u>12/3/1960</u> that I last saw the deceased alive on <u>12/3/1960</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12/3/60</u>							
ACTUAL SIGNATURE <u>Stephen N Jones</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>				809 Viers Mill Rd. Rockville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14025

14025

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>12 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hospital</u>				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>10 Valley View Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>William</u> Last <u>Detrich</u> 4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1960</u>				5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/25/197</u> 9 AGE (In years last birthday) <u>63</u> yrs IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Civil Service</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> 11 BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Henry Detrich</u> 14. MOTHER'S MAIDEN NAME <u>Rose Klink</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u> 16. SOCIAL SECURITY NO. <u> </u> 17 INFORMANT <u>W.S. Hospital Records</u> Address <u> </u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute anterior coronary artery</u> DUE TO <u>thrombosis & myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic fibrosis lung</u> DUE TO <u> </u> (c) <u>Generalized hypertensive cardio-vascular</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>30 yrs.</u> <u>20-30 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21 I certify that (I) (this hospital) attended the deceased from <u>August</u> <u>1956</u> to <u>12-18-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>12-18-</u> <u>1960</u> and that death occurred at <u>12:30</u> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D. 22b. DATE SIGNED <u>12-18-60</u> 22c. PHYSICIAN'S NAME (Type) <u>ERNEST E. HARMON</u> 22d. ADDRESS <u>9301 Calverville Rd. Silver Spring, Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Dec 21, 1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Virginia</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u> ADDRESS <u>254 Carroll St N.W.</u> 25. REC'D BY REGISTRAR <u>DEC 21 1960</u> DATE <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14110

CERTIFICATE OF DEATH

14026

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 15 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1414 "C" Street, N.E.			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Raymond		Middle Lee		Last Dorsey		4. DATE OF DEATH Month December Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 14, 1934		9. AGE (In years last birthday) 26 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Teller		10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Dorsey				14. MOTHER'S MAIDEN NAME Florence Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-44-3700		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 60X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Diabetes Mellitus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months 24 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 26, 19 60, to December 11, 19 60, that I last saw the deceased alive on December 11, 19 60, and that death occurred at 7:32 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hibbard E. Williams M.D. The Clinical Center 12/12/60 National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Hibbard E. Williams		PHYSICIAN'S NAME (Type) Hibbard E. Williams, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14 -60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 14 '60	
				24b. REGISTRAR'S SIGNATURE C. L. K. K.			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

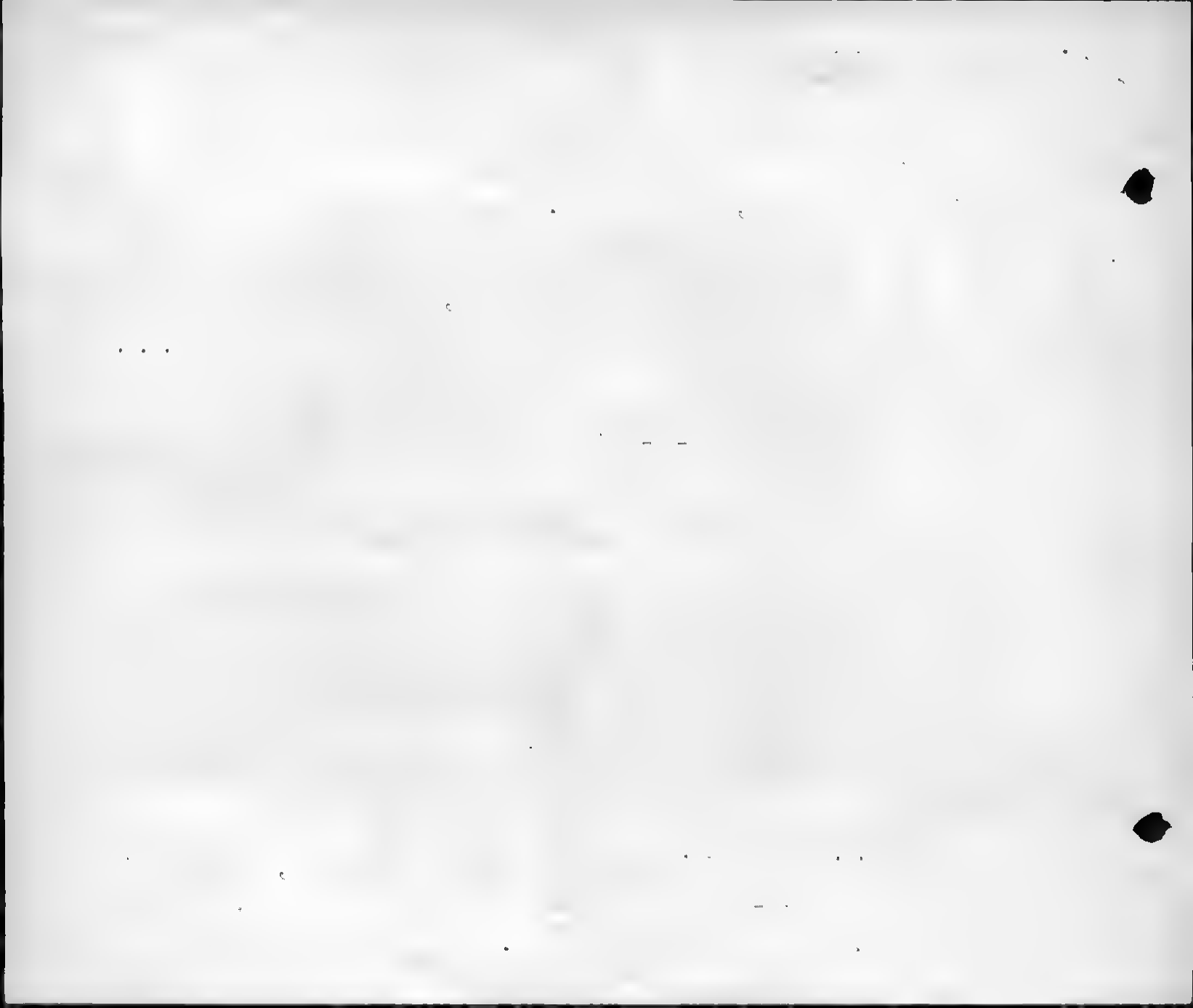
CERTIFICATE OF DEATH

14027

14111

Item 21 Film 6277 12-23-60 at

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk d. STREET ADDRESS 1021 Balview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Roosevelt Last Dozier		4. DATE OF DEATH Month December Day 1 Year 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1905
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 5 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Tyree		14. MOTHER'S MAIDEN NAME Lydia Cherry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO. 229-03-2105	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative death DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute aortic incompetence DUE TO Severe atherosclerotic aortic valve disease (c) Severe atherosclerotic aortic valve disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 27 1960 , to December 1, 1960 , that (I) (we) lost 12/2/60 the deceased alive on December 1 1960 , and that death occurred on 12/2/60 from the causes and on the date stated above 22a. SIGNATURE J.W. Gilbert M.D. 22b. DATE SIGNED 12/2/60 22c. PHYSICIAN'S NAME (Type) J.W. Gilbert M.D. 22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF	
Burial-Transit 12-3-60		12-3-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Forest Lawn Cemetery		Norfolk, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DEC 6 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



FOR STATE
HEALTH DEPT.

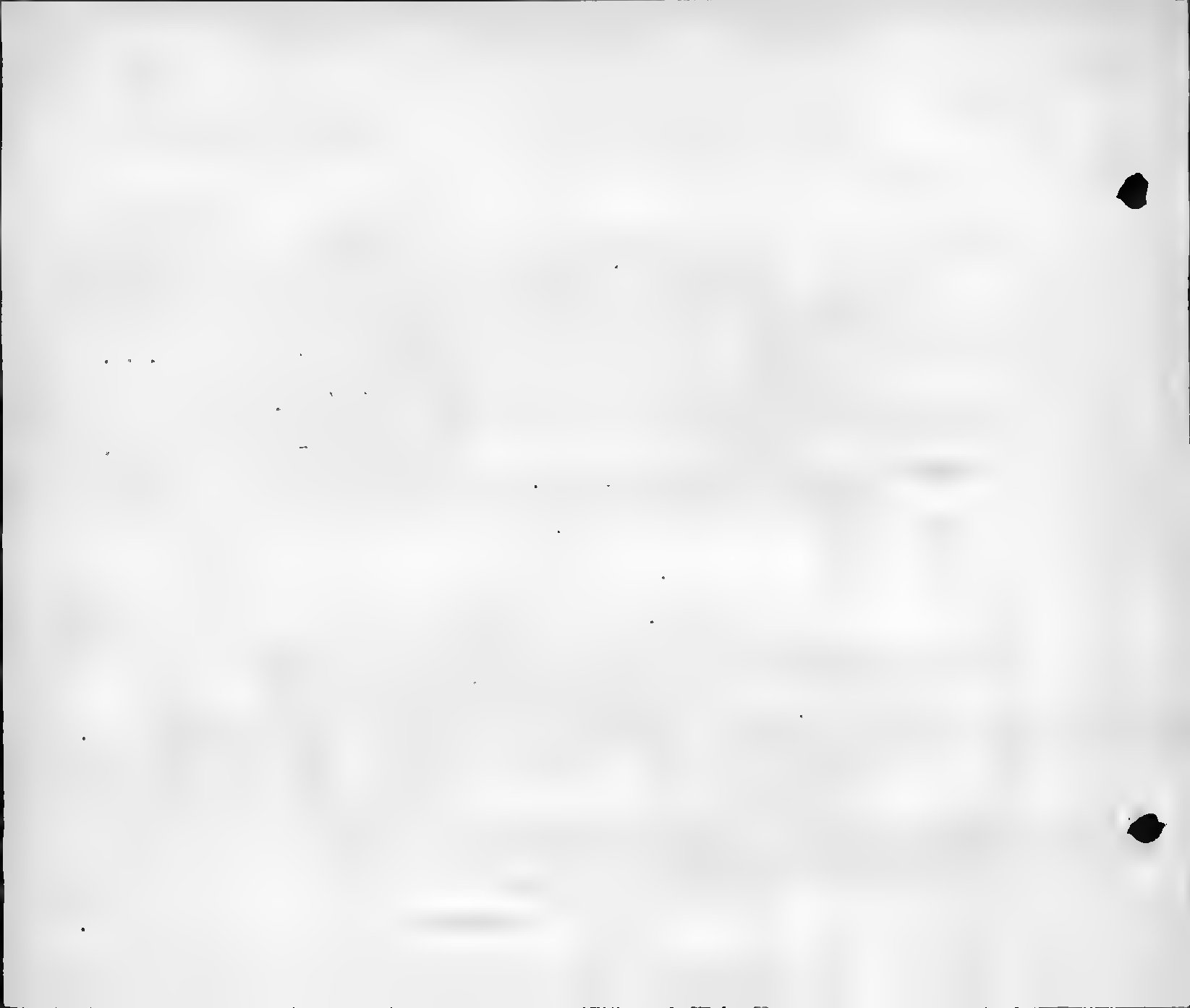
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14028

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 day 4 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5400 Glenwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> <u>devere</u> <u>Drayton</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/78</u>
9. AGE (in years last birthday) <u>82</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	11. BIRTHPLACE (State or foreign country) <u>Aiken, South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Elliott Drayton</u>	
14. MOTHER'S MAIDEN NAME <u>Jessie Bowen E. Mackay</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records- Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible Brain Damage</u>			
DUE TO (b) <u>Cerebral Anoxia</u>			
DUE TO (c) <u>Cardiac Arrest</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of rt hip</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down 3 steps at home</u>	
20c. TIME OF INJURY Hour <u>6:15</u> a.m. <u>PM</u> <u>12/7/60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) <u>Prince Georges Co.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File in 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

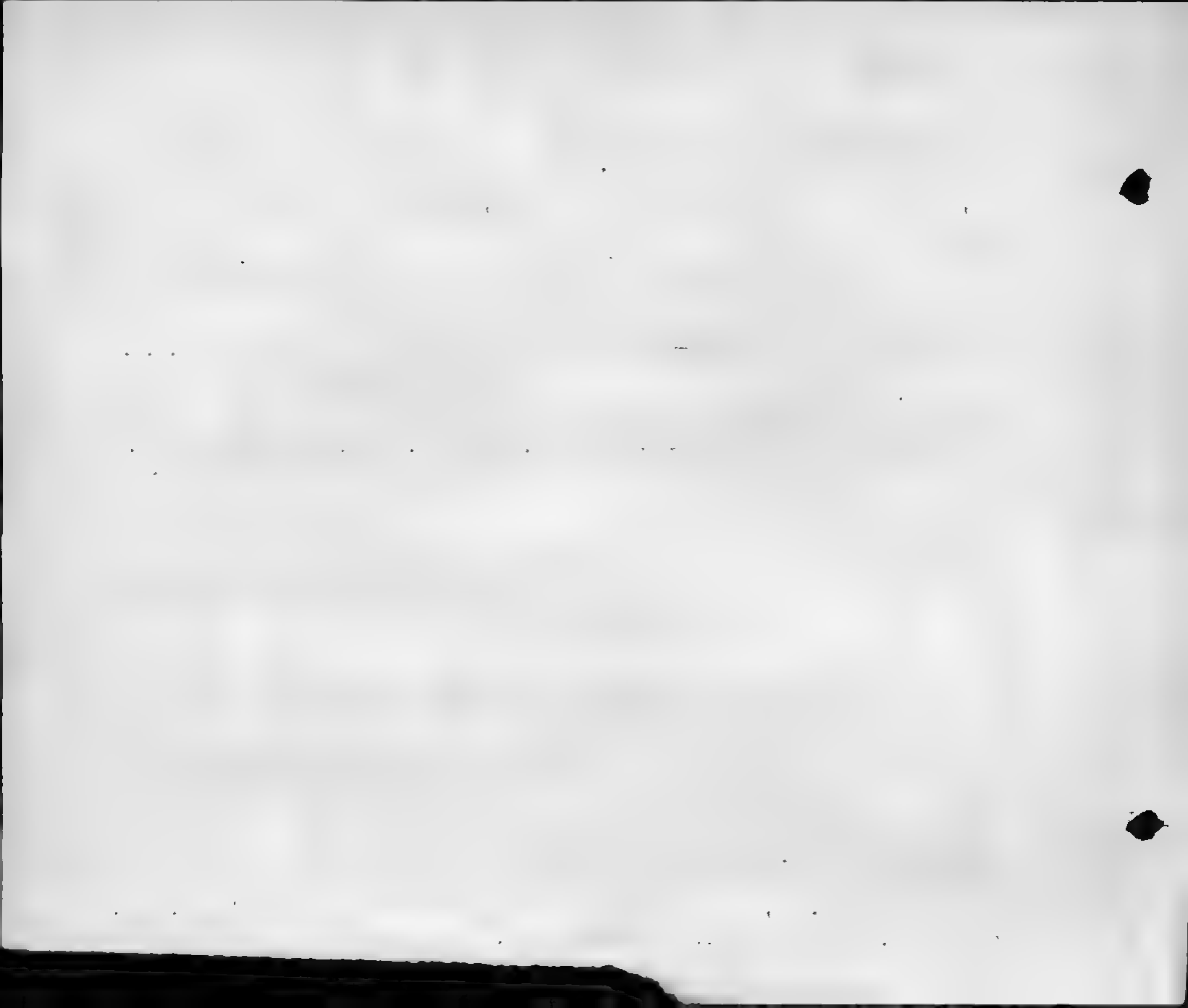
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14029

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 10,208 PROCTOR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER Walter DUKE		4. DATE OF DEATH Month Day Year DEC. 14 1960		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/14/94		9. AGE (in years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter A. Duke		14. MOTHER'S MAIDEN NAME Florence MARTHA SMELTZER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WW #1	
16. SOCIAL SECURITY NO. 220-09-5348		17. INFORMANT Mrs. Gladys G. Duke, 10208 Proctor St. Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) 1720-1 Coronary occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart		NAME (Type) FRANK J. BROSCART		DATE SIGNED 12-15-60		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Prince George's Co., Md.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC., Silver Spring, Md. Raymond A. Ziska		24a. REC'D BY REGISTRAR DEC 19 1960		24b. REGISTRAR'S SIGNATURE		25. ADDRESS (Street, city, town, or county)		26. ADDRESS (Street, city, town, or county)		27. ADDRESS (Street, city, town, or county)		28. ADDRESS (Street, city, town, or county)	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No.

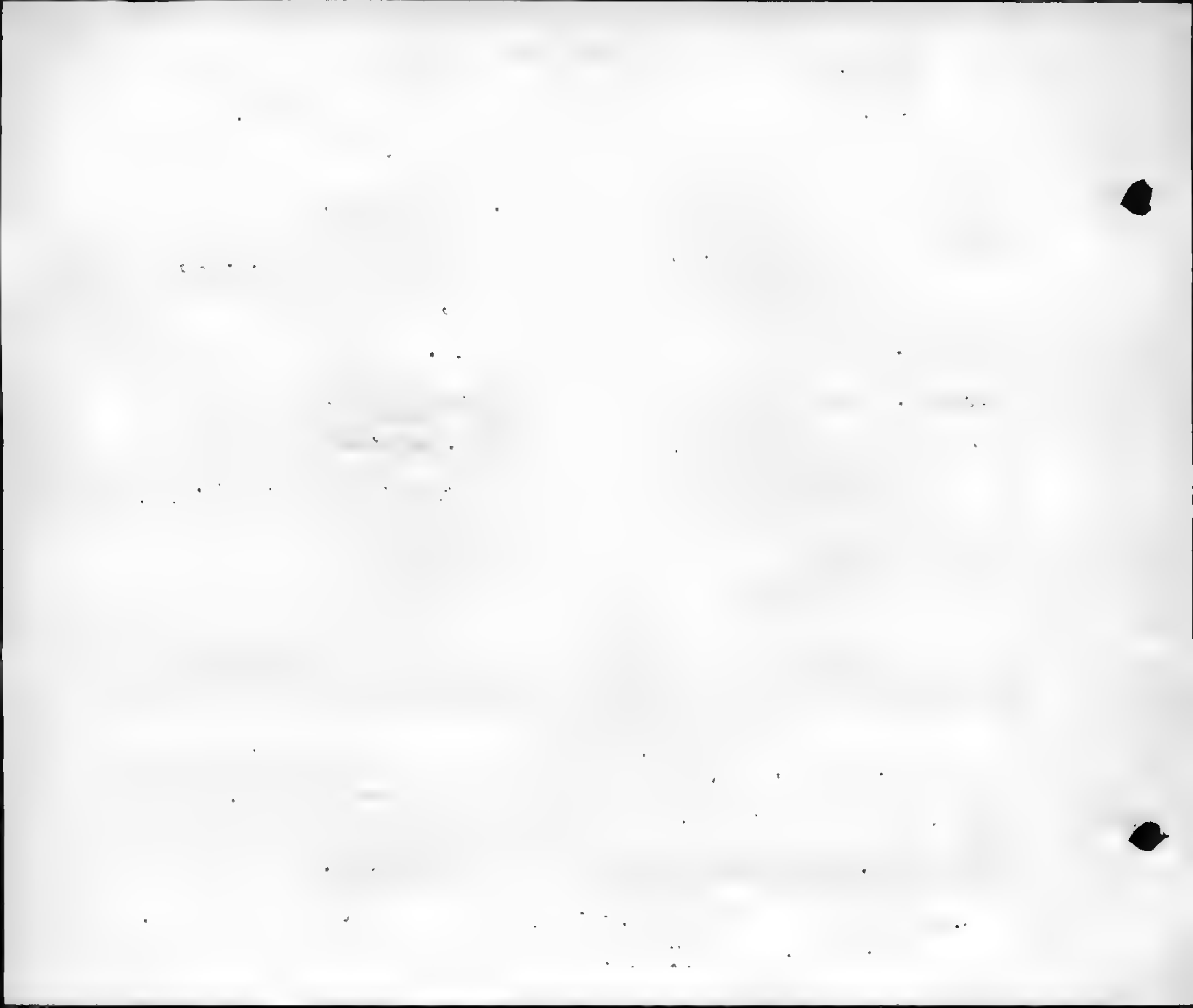
14030

14113

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodfield c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION X		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Woodfield d. STREET ADDRESS Rt. #1 Gaithersburg, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hilda Pauline Duvall		4. DATE OF DEATH Month Day Year Dec. 11, 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1896
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Darius W. Burns		14. MOTHER'S MAIDEN NAME Campsidell Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
INFORMANT Duvall		Address Norman L. Woodstock Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 175.0 IMMEDIATE CAUSE (a) Cancer of stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) peritoneal metastases DUE TO (c) 1 year INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1959 to December 11, 1960 that I last saw the deceased alive on December 10, 1960 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 12/13/60			
ACTUAL SIGNATURE James P. Kerr		M.D. Damascus, Md.	
PHYSICIAN'S NAME (Type) Dr. James Kerr		Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Jennings Chapel	22d. LOCATION (City, town, or county) (State) Howard County Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber Laytonville Md.		24a. REC'D BY REGISTRAR DATE DEC 15 '60	
24b. REGISTRAR'S SIGNATURE D. J. [Signature]			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14114 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14031

Item 8 film 278 1-6-61 at

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b S.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
d. STREET ADDRESS 604-Alden Ave.

3. NAME OF DECEASED (Type or print) Sharon Elaine Duval
First Middle Last
4. DATE OF DEATH Dec. 27 1960
Month Day Year

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 11/11/1945
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 15 yrs IF UNDER 1 YEAR F UNDER 24 HRS
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl. 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm. Duval 14. MOTHER'S MAIDEN NAME Helene E. King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
8 4 4 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Sled ran into large tree while sleigh riding

20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 12-27-60 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home Farm 20f. (City or town) Montgomery (County) Montgomery (State) MD

21. I certify that I took charge of the remains described above, held an autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Broschant ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 12-27-60
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 12/30/60 22c. NAME OF CEMETERY OR CREMATORY Garthman 22d. LOCATION (City, town, or country) Proctorville (State) MD

23. FUNERAL DIRECTOR Emmett G. Fathner ADDRESS Garthman 24a. REC'D BY REGISTRAR JAN 3 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

Handwritten text, possibly a signature or name, is visible in the center of the page.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

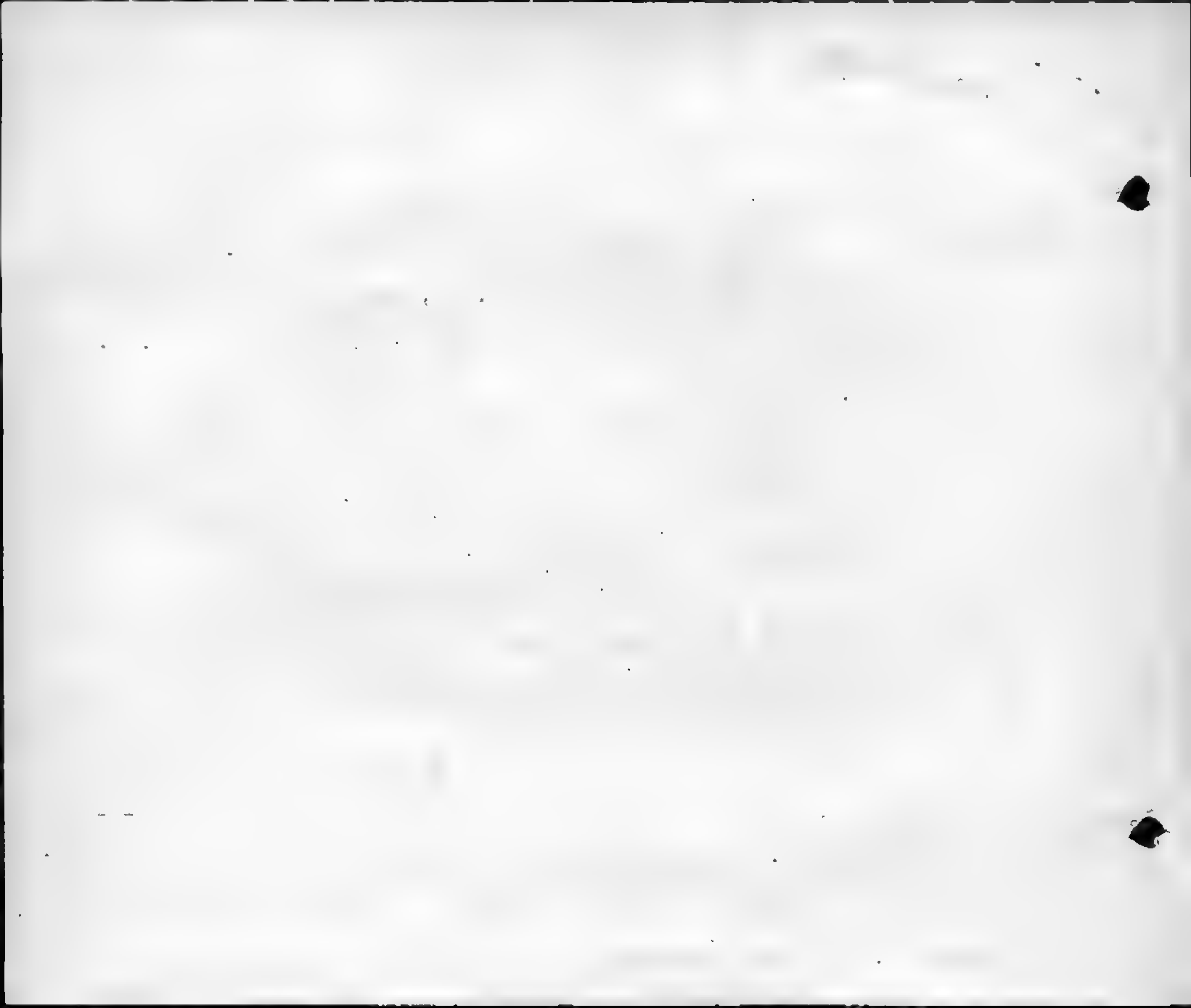
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 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14081

14032

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1200 Harrison Street	
3 NAME OF DECEASED (Type or print) First JOHN Middle ARTHUR Last ENGLAND		4. DATE OF DEATH Month Dec. 6, Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1883
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Circuit Court	
11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John G. England		14. MOTHER'S MAIDEN NAME Annie Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 578-28-1639	
17. INFORMANT Son		Address Owings England Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Peritonitis 578X DUE TO Perforation of Transverse Colon Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Also, obstructive jaundice due to common duct stone and bleeding 2 weeks (c) chronic gastritis and peptic ulcer			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month 12 Day 6 Year 1960 Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 21, 1960 to Dec 6, 1960 that (I) last saw the deceased alive on Dec 6, 1960 and that death occurred on Dec 6, 1960 at 11:15 M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur F. Woodward M.D.		22b. DATE SIGNED 12-6-60	
22c. PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD		22d. ADDRESS 41 West Wood Lane, Rockville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/8/60	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	23d. LOCATION (City, town, or county) (State) Rockville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Clifford S. Evans		DATE DEC 8 '60	



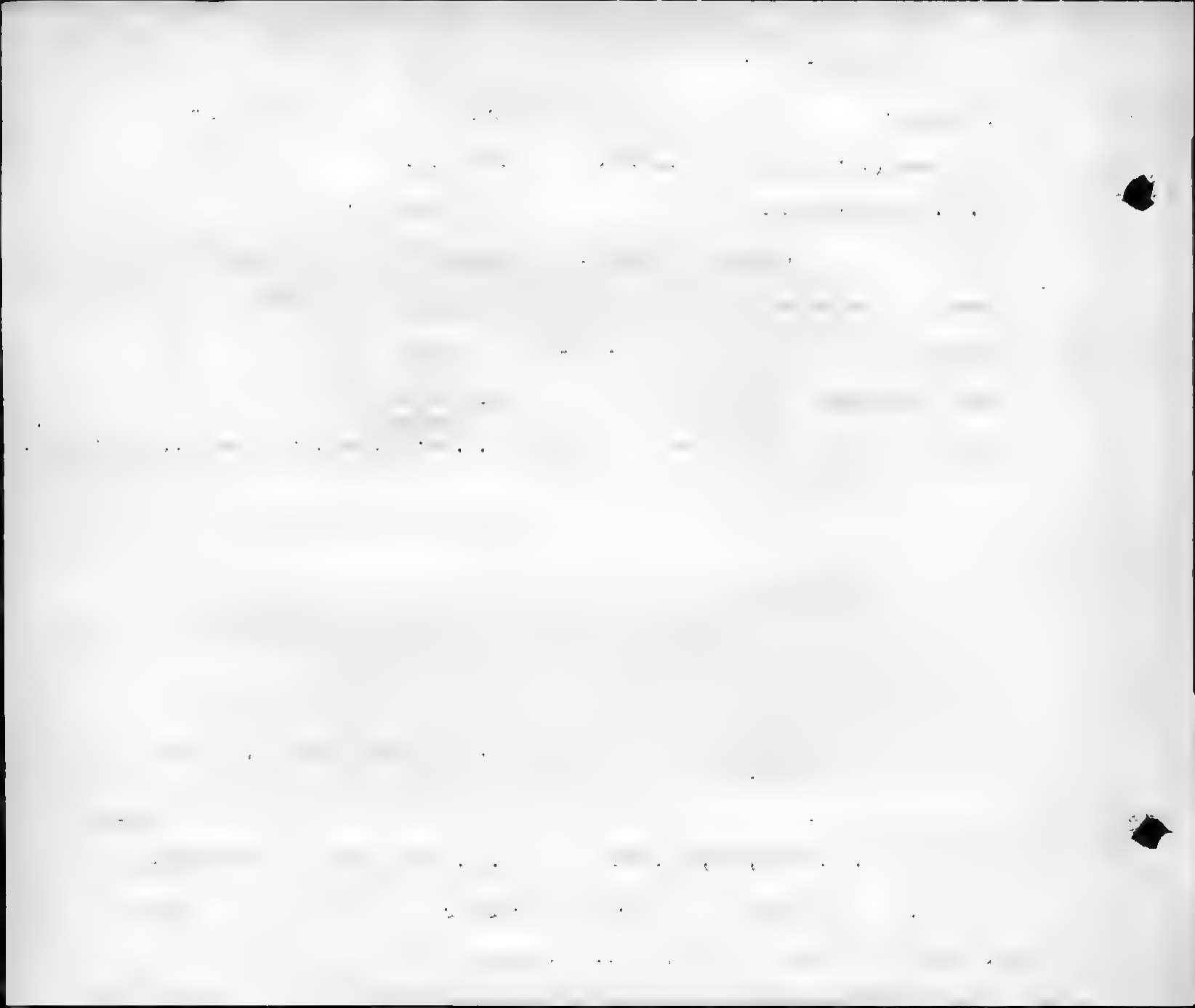
14115

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14033

1. PLACE OF DEATH a. COUNTY Montgomery				b. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 12 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 2811 Peregrine Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Jessie Muriel ENGLISH				4. DATE OF DEATH Month Day Year December 27 1960											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-78		9. AGE (in years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Canada				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James MC CORMICK				14. MOTHER'S MAIDEN NAME Mary PETTY											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Grandson				Address Va. LtCol M.C. Murphy, USA, 15 Eton Ct., Alexandria,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month Day Year Hour a m p m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that he (this hospital) attended the deceased from Dec. 15 1960 to Dec. 27 1960 , that he (we) last saw the deceased alive on Dec. 27 1960 , and that death occurred at 6P M, from the causes and on the date stated above.															
22a. SIGNATURE R. G. Muth				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 12-28-60							
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN															
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 12-31-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory		23d. LOCATION (City, town, or county) Suitland Maryland							
24. FUNERAL HOME'S SIGNATURE Jos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC				25a. REC'D BY REGISTRAR DEC 30 '60		25b. REGISTRAR'S SIGNATURE John S. Kneib									



CERTIFICATE OF DEATH

Reg. Dist. No.

14034

14008

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 QUANT ACRES DRIVE</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15</u>	
f. STREET ADDRESS <u>201 Quant Acres Drive</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>Daniel</u> Last <u>Feick</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber (Self-employed) BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Feick</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>186 28 7564</u>	
INFORMANT <u>Gertrude McKenna</u>		Address <u>Silver Spring, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Hypertensive arteriosclerosis</u> INTERVA. BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>6 mo</u> <u>Yrs.</u>		18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>Dec. 7, 1960</u> , that I last saw the deceased alive on <u>Dec. 7, 1960</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D.		ADDRESS (Street, city or town, state) <u>345 University Blvd, West</u> DATE SIGNED <u>12/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF	
TRANS. & BURIAL 12/10/60		VERSAILLES CEMETERY	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>VERSAILLES CEMETERY</u>		<u>McKEESPORT, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY, INC. SILVER SPRING, MD.</u> <u>Raymond A. Giokas</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

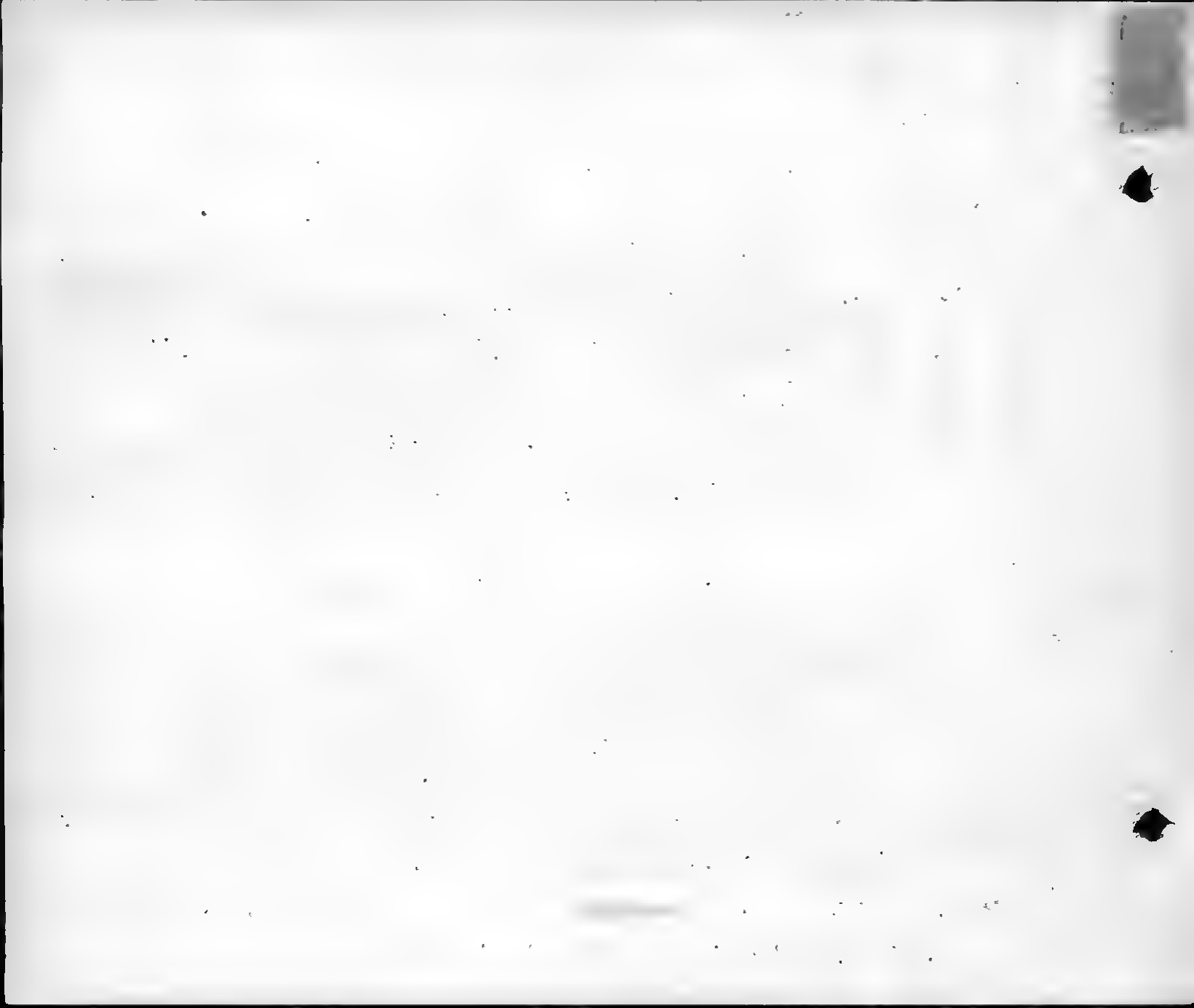
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

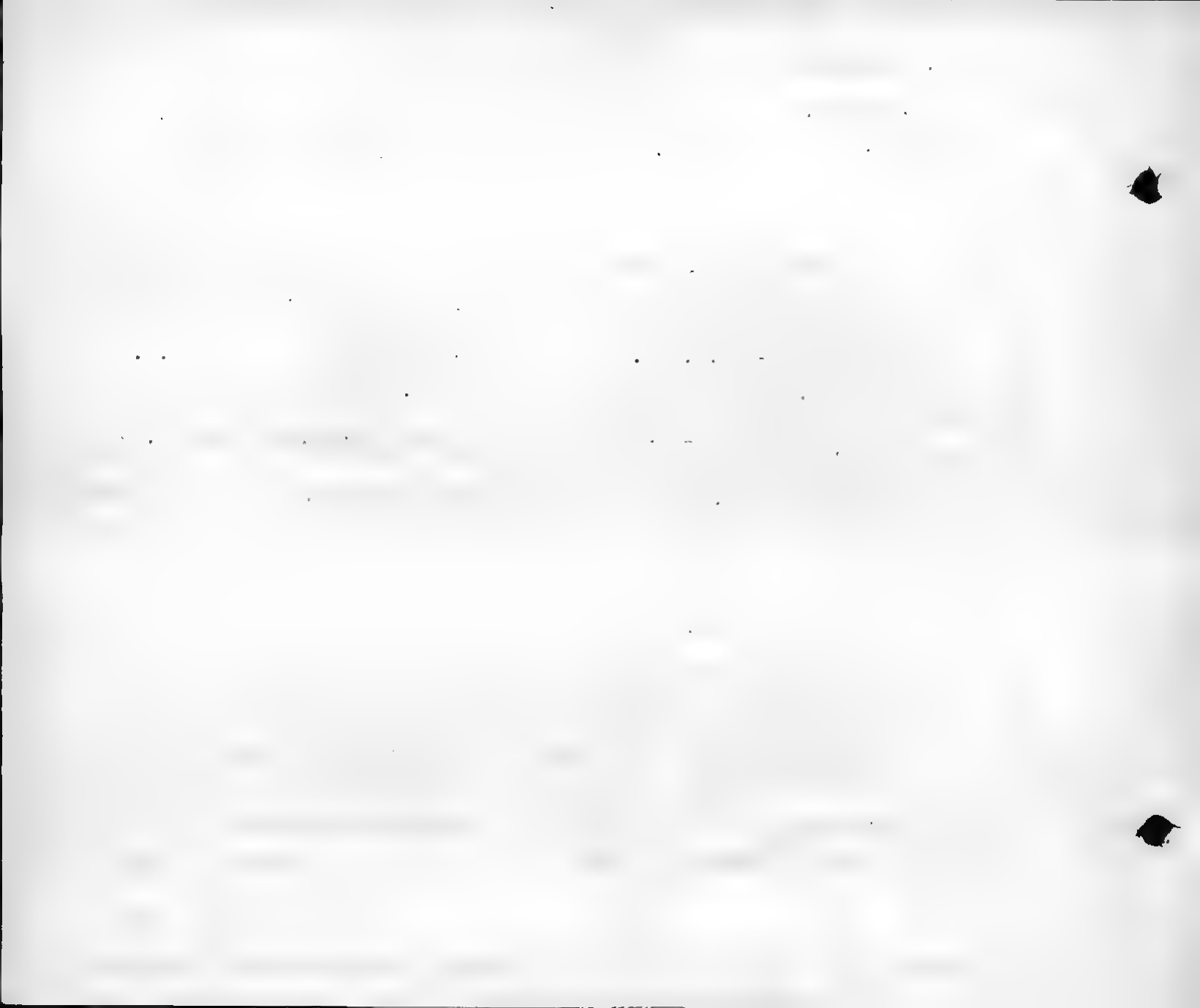
14035

14116

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Montgomery			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville				c LENGTH OF STAY IN 1b 60 yrs			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Spencer Last Fisher				4. DATE OF DEATH Month December Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 16-1894	
9. AGE (in years last birthday) 66 yrs.		10. F UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier--U.S. Gov.				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			
13. FATHER'S NAME Millard C. Fisher				14. MOTHER'S MAIDEN NAME Mary E. Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO 577-18-1572			
17. INFORMANT Mrs Spencer Fisher, Barnesville, Md				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atheriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 30 hours 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 Dec , 19 60 , to 4 Dec , 19 60 that I last saw the deceased alive on 4 Dec , 19 60 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DAWSONVILLE DATE SIGNED 12/5/60							
ACTUAL SIGNATURE John C. Fawcett M.D.				PHYSICIAN'S NAME (Type) JOHN C. FAWCETT M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/7/60			
22c. NAME OF CEMETERY OR CREMATORY St Marvs				22d. LOCATION (City, town, or county) (State) Barnesville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton				24a. REC'D BY REGISTRAR DATE DEC 9 '60			
ADDRESS Barnesville, Md				24b. REGISTRAR'S SIGNATURE C. L. H. & K. H.			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



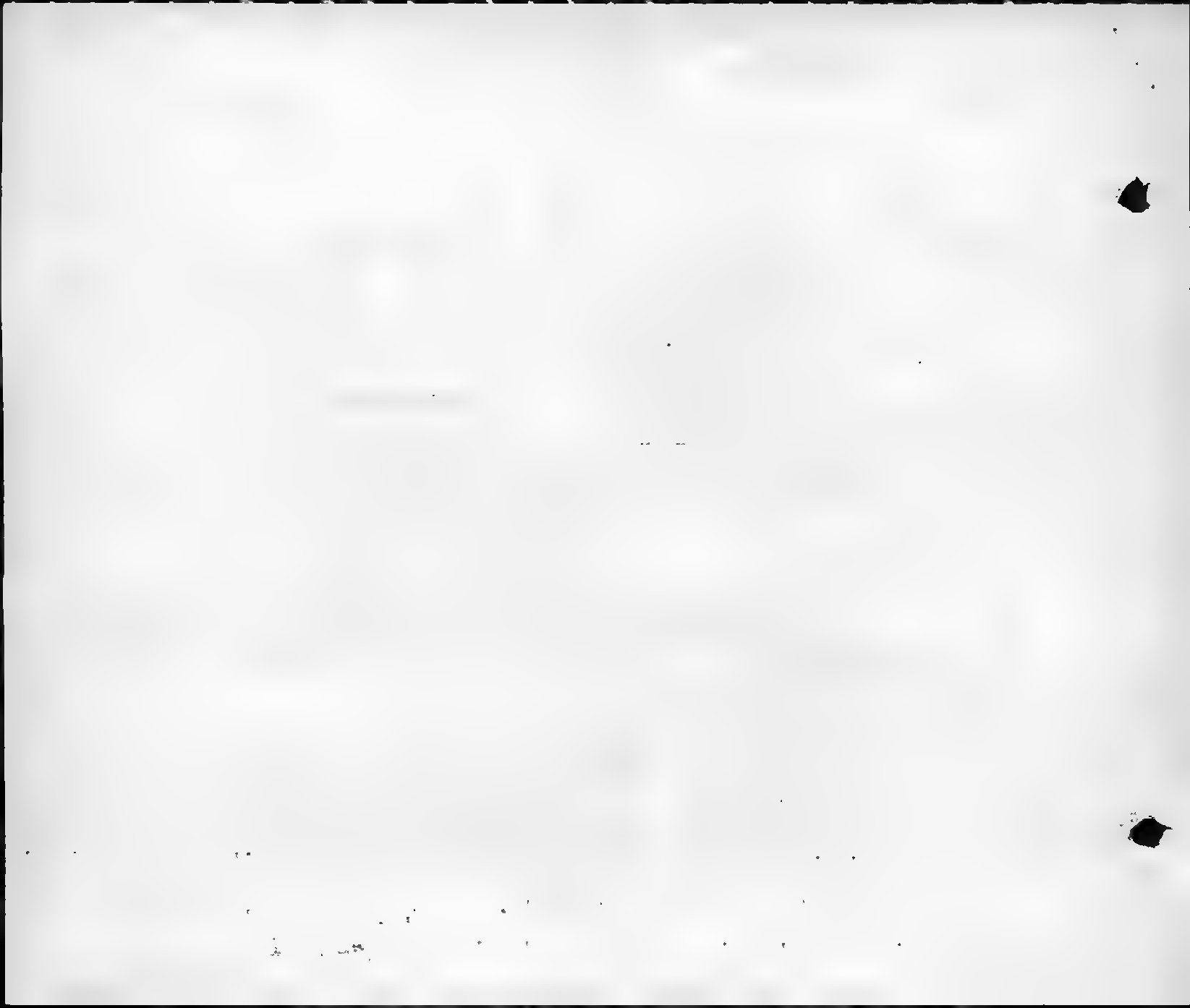
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14030

14036

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b <u>12 hrs</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7304 Birch Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Lillian Ada Fisher</u> First Middle Last				4. DATE OF DEATH <u>Dec. 6 1960</u> Month Day Year											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-08</u>		9. AGE (In years last birthday) <u>52</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during last year, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>				11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Charles E. Pyle</u>						14. MOTHER'S MAIDEN NAME <u>Florence McCluskey</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>578-12-1387</u>		17. INFORMANT <u>Hospital Admitting Record</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 CARCINOMA OF COLON</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>12-5 1960</u> to <u>12-6 1960</u> that (I) (we) last saw the deceased alive on <u>12-6 1960</u> and that death occurred at <u>9 AM</u> from the causes and on the date stated above															
22a. SIGNATURE <u>L. B. SNOW</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>L. B. SNOW</u>						22d. ADDRESS <u>7950 New Hampshire Ave., Langley Park, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>				23d. LOCATION (City, town, or county) <u>ARLINGTON, VIRGINIA</u> (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>						25a. REC'D BY REGISTRAR <u>DEC 14 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>					

MEDICAL CERTIFICATE



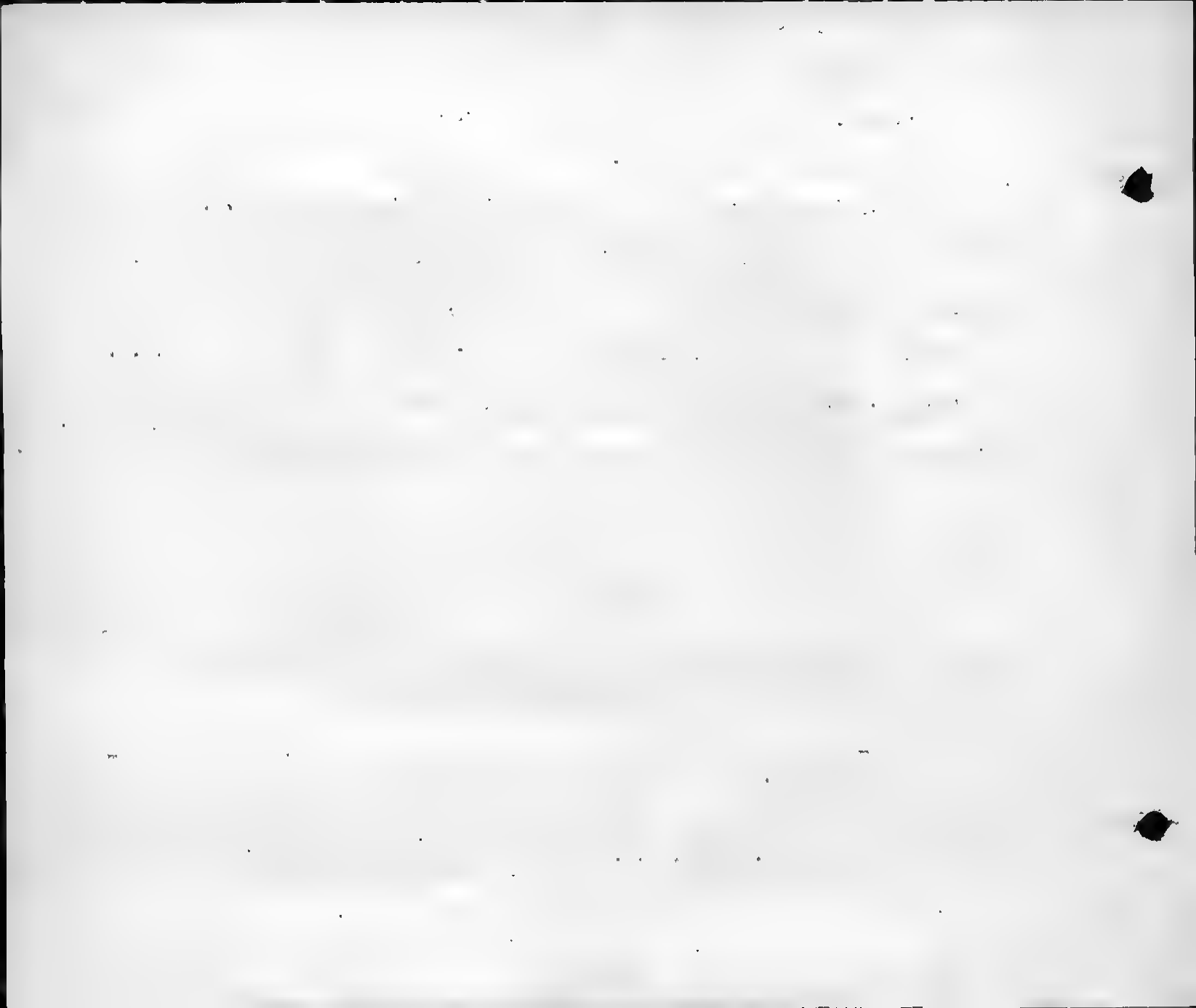
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14037

14117

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Violet Middle Sylvia Last Frankhouser				4. DATE OF DEATH Month December Day 19 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 20, 1910	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis S. Yassel			
14. MOTHER'S MAIDEN NAME Olga Kerkow				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Not available				17. INFORMANT The Medical Record Address The Clinical Center National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (if this hospital) attended the deceased from November 21, 1960 to December 19, 1960 , that (if we) last saw the deceased alive on Dec. 19, 1960 and that death occurred at 1:29 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Sanford F. Kuvin, M.D.</i> M.D.				22b. DATE SIGNED 12/19/60			
22c. PHYSICIAN'S NAME (Type) Sanford F. Kuvin, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/22/60		23c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery		23d. LOCATION (City, town, or county) (State) Tall Church, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Charles Funeral Home</i>				25a. REC'D BY REGISTRAR DEC 23 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

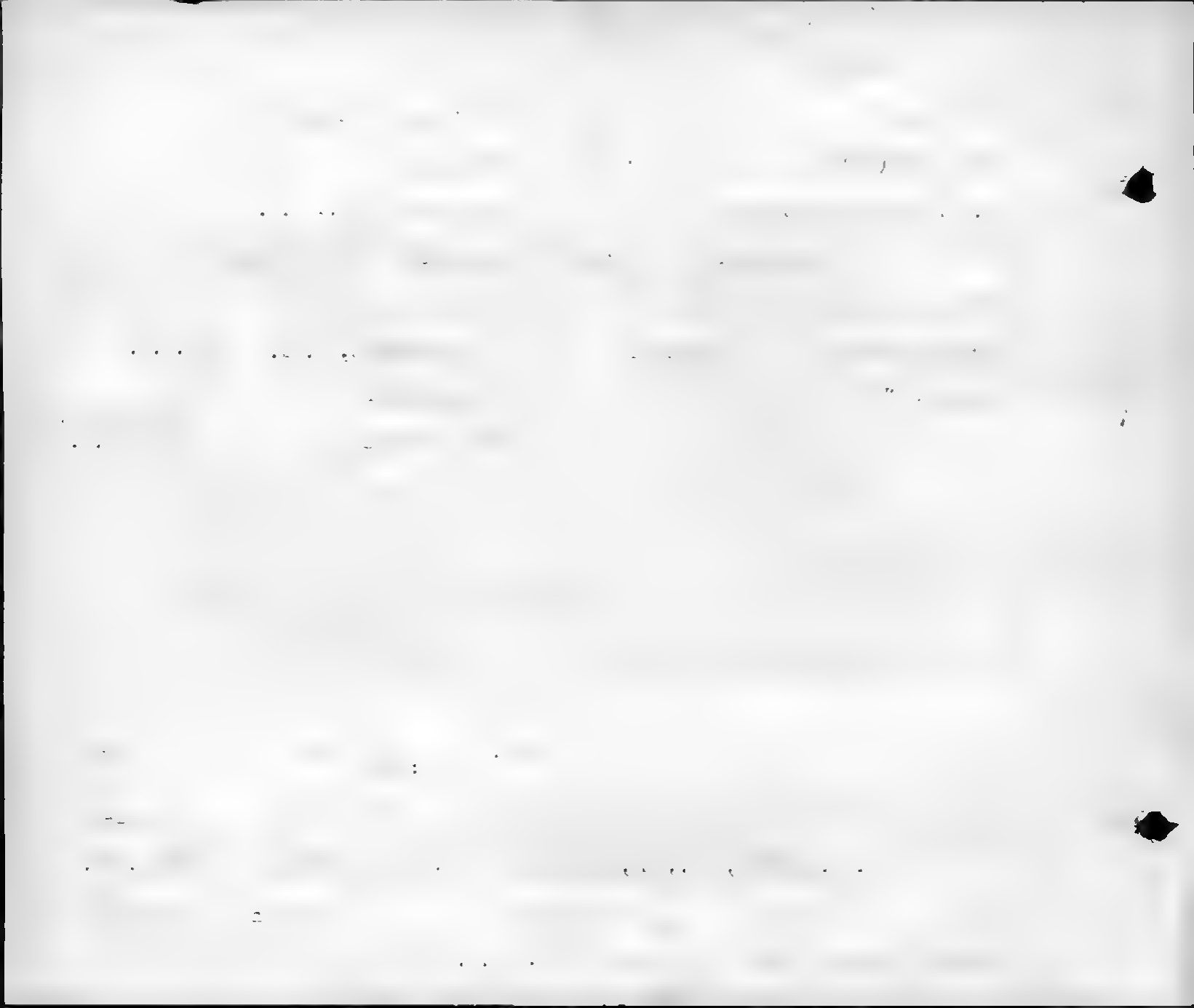
14118

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14038

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 53 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Josephine Brown FRANKLIN				4. DATE OF DEATH Month Day Year December 2 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-97	
9. AGE (In years last birthday) 63 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse-Attendant		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. BROWN				14. MOTHER'S MAIDEN NAME Serena CALLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT (H) John W. Franklin, 3108 Park Place, N.W.				Address Washington, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 464X Pulmonary infarction, right middle and lower lobes. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus, pulmonary artery, right (c) Phlebotrombosis, left common iliac							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (H) (this hospital) attended the deceased from Oct. 10 1960 to Dec. 2 1960 , that we last saw the deceased alive on Dec. 2 1960 , and that death occurred at 8:29AM , from the causes and on the date stated above.							
22a. SIGNATURE F. M. Highly, Jr.				22b. DATE SIGNED 12-2-60			
22c. PHYSICIAN'S NAME (Type) F. M. HIGHLY, JR., LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Magruder Funeral Home, 2311 Nicholas Ave., S.E.				25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE Charles S. Frank	

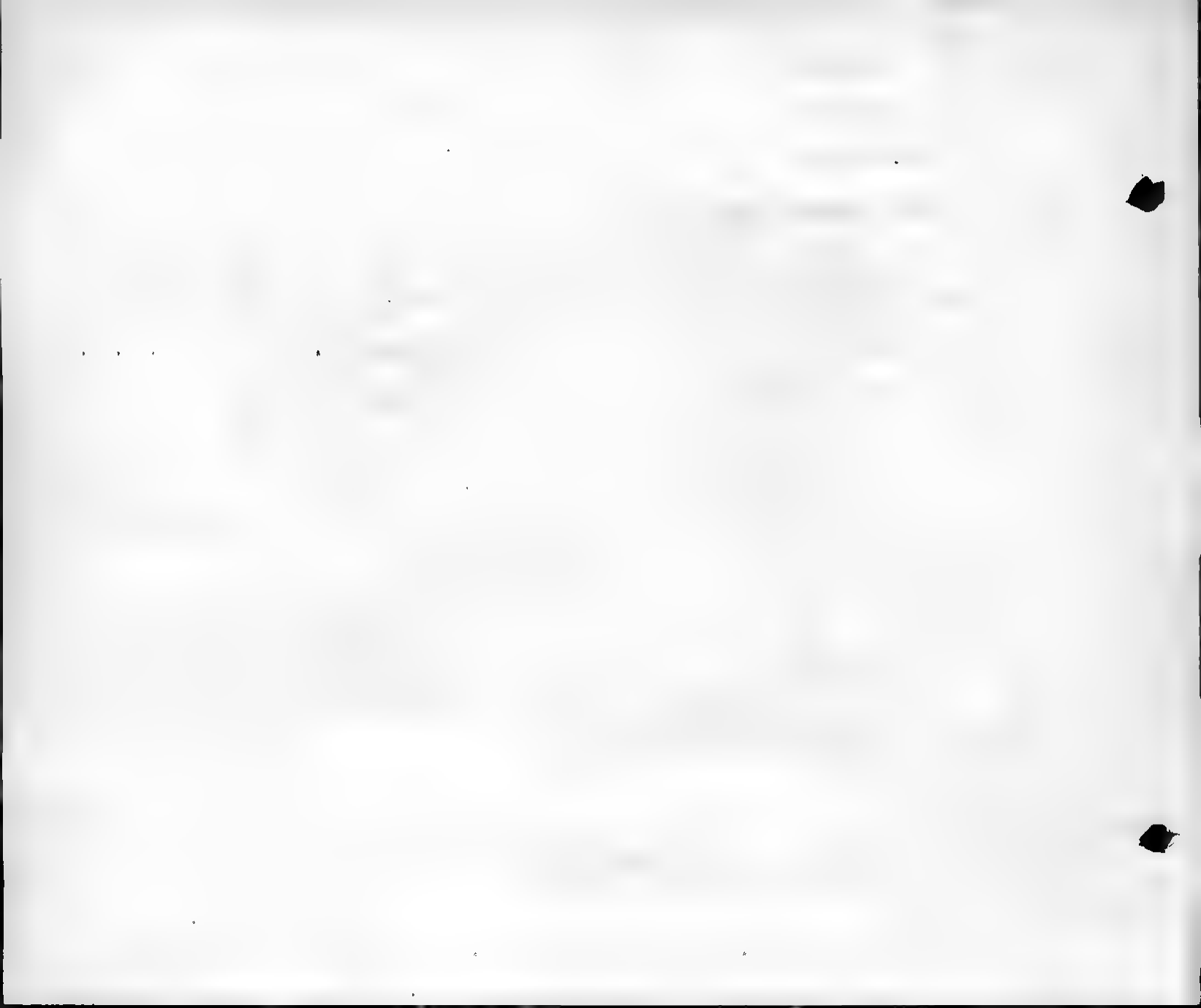
Magruder Funeral Home, 2311 Nicholas Ave., S.E.



Reg. Dist. No. 14039

14068

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hamilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kate Aiken Frasier				4. DATE OF DEATH Month Day Year 12 30 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1867	
9. AGE (In years last birthday) 93 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Cass County, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas William Frasier				14. MOTHER'S MAIDEN NAME Eliza Aiken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 10-20 , 19 60 , to 12-30 , 19 60 , that I last saw the deceased alive on 12-29 , 19 60 , and that death occurred at 2:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7720 Wisconsin Ave. DATE SIGNED 12-30-60 ACTUAL SIGNATURE James W. Egan M.D. PHYSICIAN'S NAME (Type) JAMES W. EGAN, Md. Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-61		22c. NAME OF CEMETERY OR CREMATORY Iva Hill		22d. LOCATION (City, town, or county) (State) Upperville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.				ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 4 '61	
				24b. REGISTRAR'S SIGNATURE William S. Hines			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

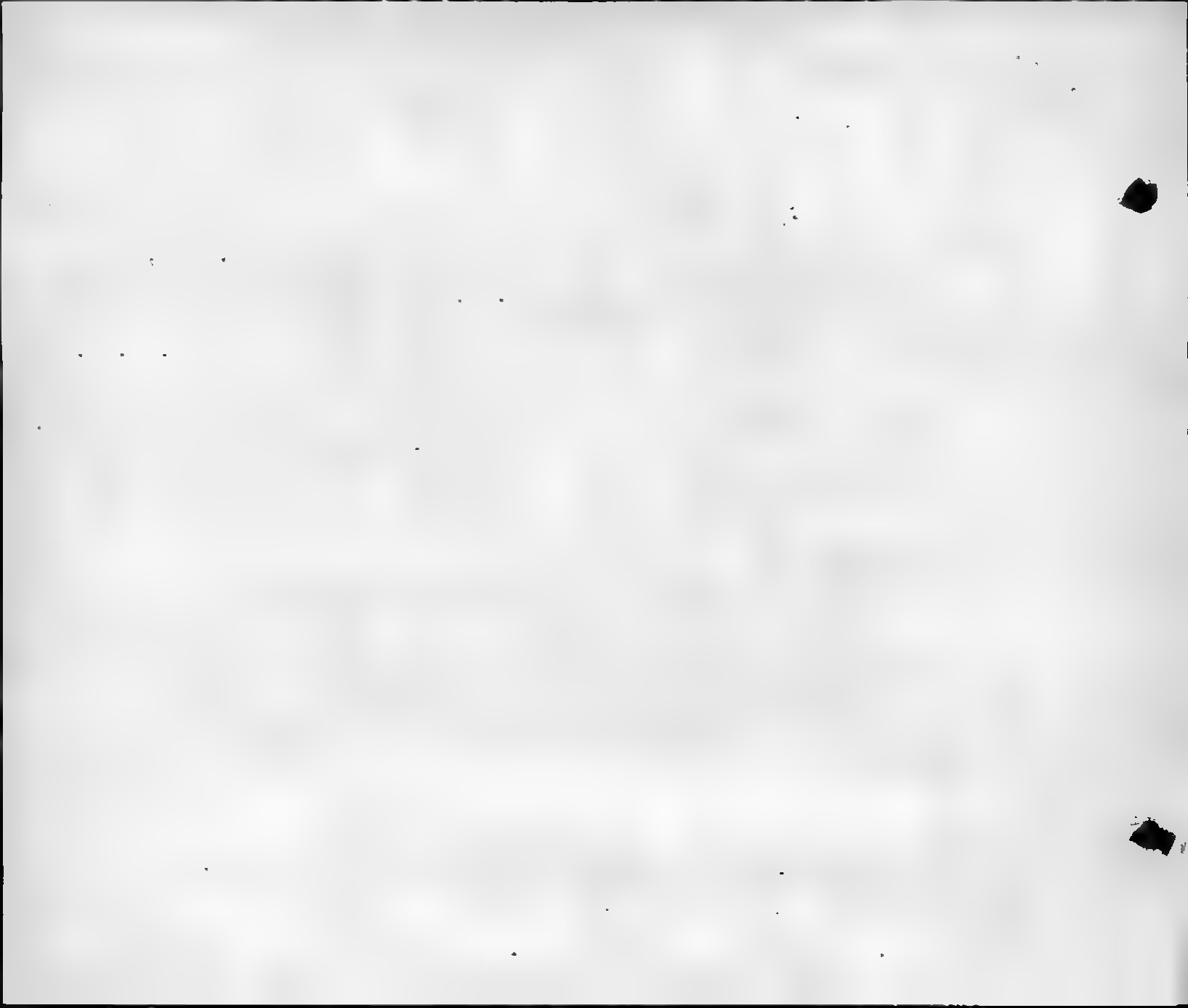
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14040

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 3 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Westgate)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Congressional Manor Sanitarium		d. STREET ADDRESS 5142 Worthington Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE Middle GERHARDT Last GERHARDT		4. DATE OF DEATH Month Dec. Day 2, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Schneider	
14. MOTHER'S MAIDEN NAME Lauckhardt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Son Harrison A. Gerhardt Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Sigmoid DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Months			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED Dec. 2, 1960	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-2-60		22b. DATE THEREOF 12-2-60	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE DEC 6 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>	



CERTIFICATE OF DEATH

Reg. Dist. No.

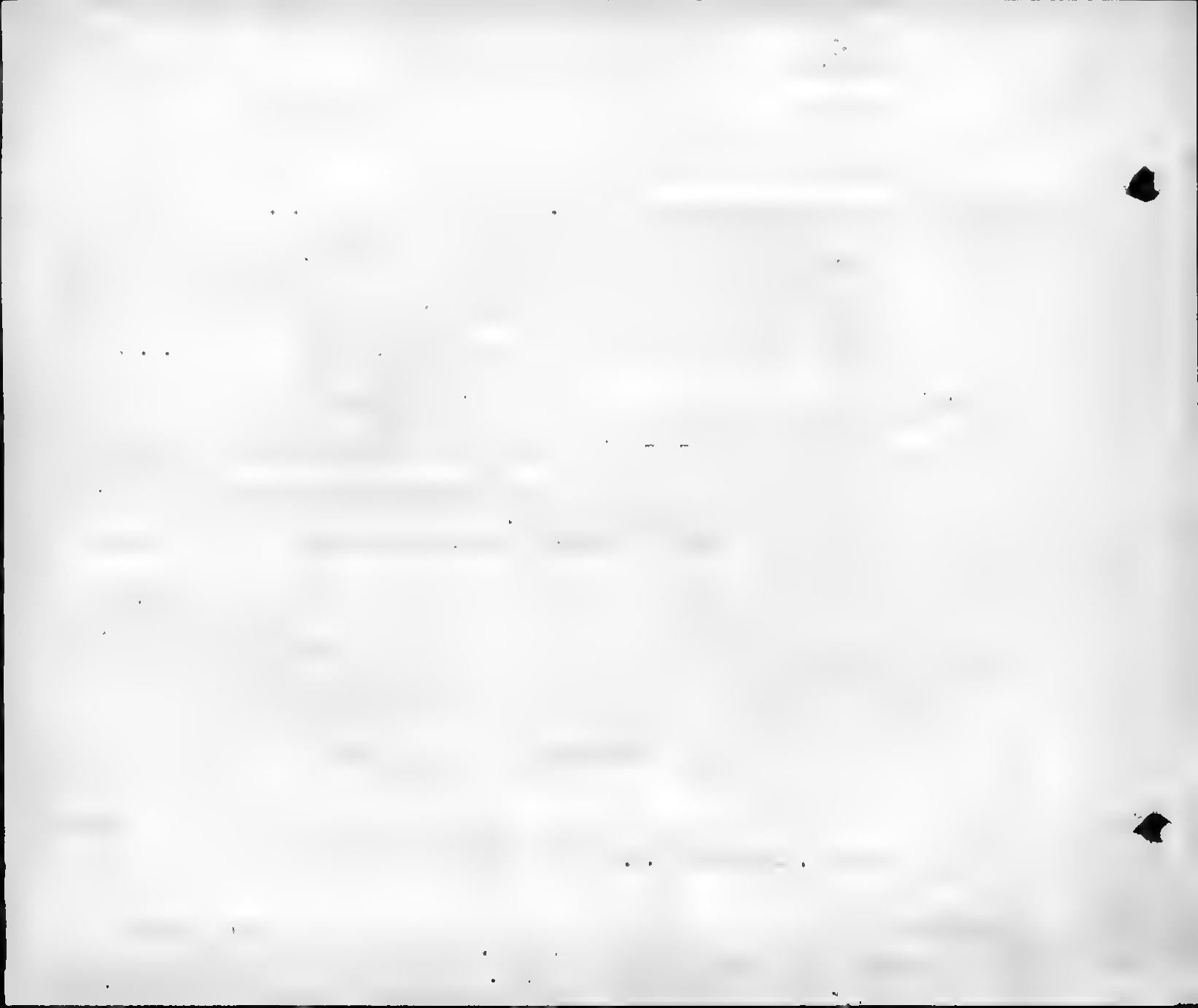
14041

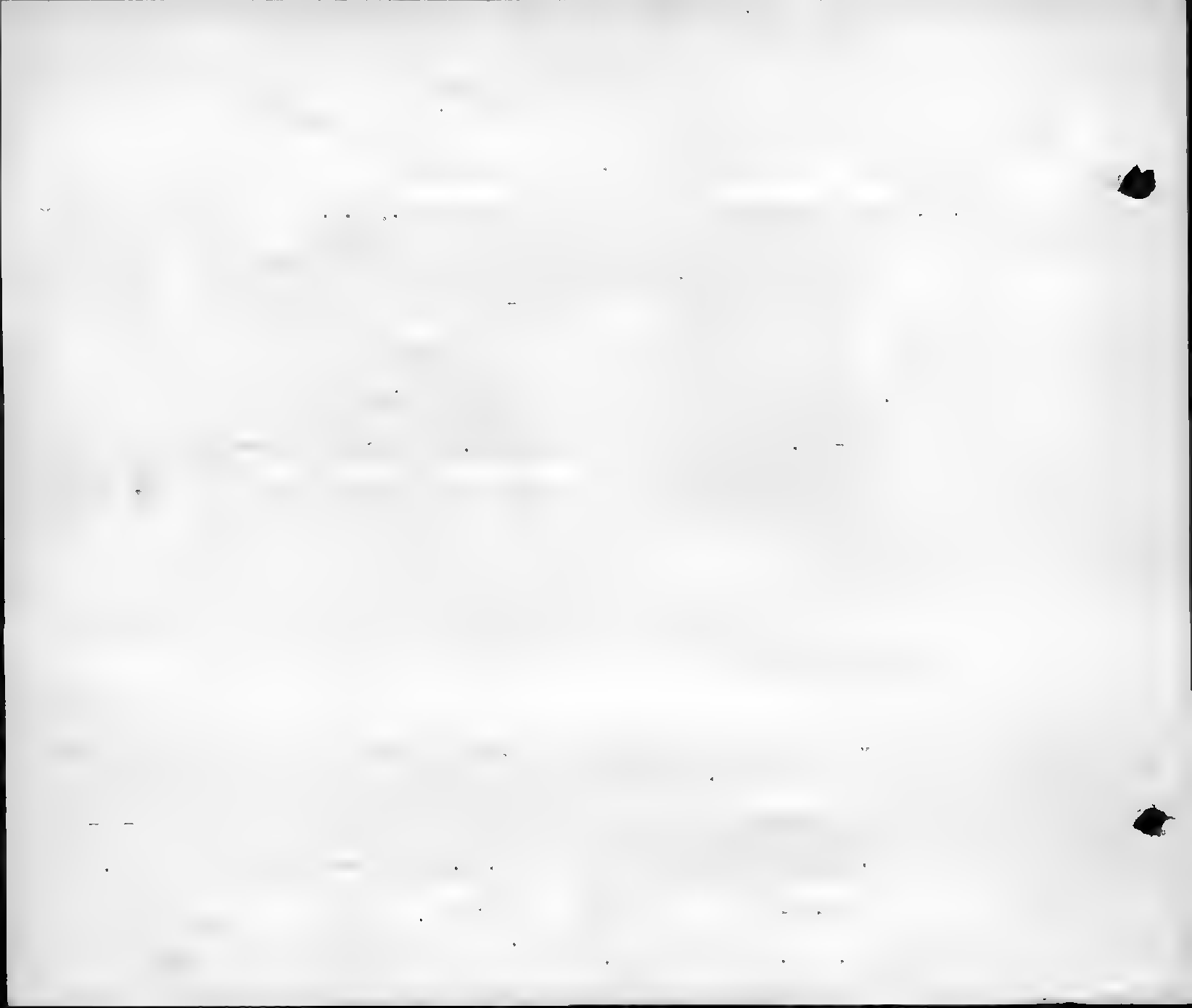
14120

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived) f. Institution Res. before admission) b. STATE District Of Columbia c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 417 - 12th Street, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carroll Middle Robert Last Gibbs		4. DATE OF DEATH Month December Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1915
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months 4 Days 7 Hours X Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Gibbs		14. MOTHER'S MAIDEN NAME Elizabeth Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16. SOCIAL SECURITY NO. 578-22-0716	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Head of Pancreas with invasion of DUE TO Gastro-jejunosomy. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Massive Gastro-intestinal hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Years hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 25, 1960 to December 1, 1960 that I last saw the deceased alive on December 1, 1960 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/3/60 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Robert B. Scoggins, M.D.		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type)		DATE DEC 5 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Fort Myer, Virginia	
23. GENERAL DIRECTOR'S SIGNATURE Alexander S. Pope		24a. REC'D BY REGISTRAR 414 15th. St. S. E.	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		DATE DEC 5 '60	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





14009

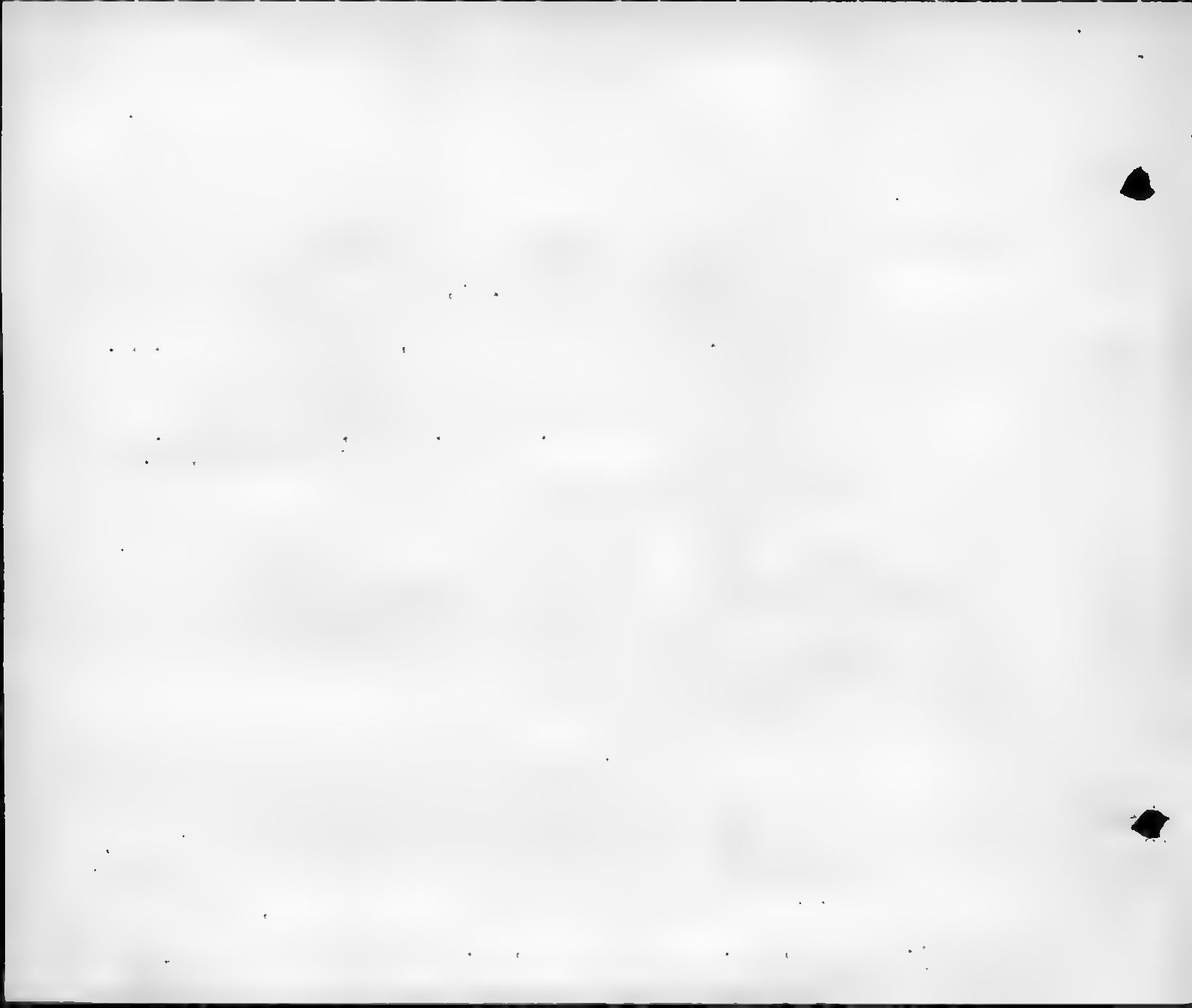
1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

14043

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN lb 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2812 DAWSON STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK William GLANTZ				4 DATE OF DEATH December 6, 1960			
5 SEX MALE		6 COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH AUG. 10, 1872	
9 AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY (retired)				10b. KIND OF BUSINESS OR INDUSTRY Pa. Welfare Board		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHRISTIAN GLANTZ				14. MOTHER'S MAIDEN NAME CATHERINE STRAHLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Elsie S. Glantz, 2812 Dawson St. Silver Spring, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Generalized Arteriosclerosis DUE TO Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs. 5 yrs. 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from July 1953 to 12/6/60 , that (I) (we) last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 12 noon from the causes and on the date stated above							
22a SIGNATURE Belden R. Reap				22b. DATE Dec. 6, 1960			
22c PHYSICIAN'S NAME (Type) BELDEN R. REAP, M.D.				22d. ADDRESS 11502 GRANDVIEW AVENUE, SILVER SPRING, MARYLAND.			
23a BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b DATE THEREOF 12/9/60		23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC.				ADDRESS SILVER SPRING, MD.		25a REC'D BY REGISTRAR DATE DEC 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kram			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14069

CERTIFICATE OF DEATH

Reg. Dist. No.

14046

1 PLACE OF DEATH a. COUNTY Montg b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY in 1b 3 yrs		d. STREET ADDRESS 106 N. Frederick Ave	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Flossie Pearl Graham		4 DATE OF DEATH Dec 21 19 60	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 18th 1909
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR 0 Months 3 Days 0 Hours 0 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY " "	
11 BIRTHPLACE (State or foreign country) Taswell Va.		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James H. Collins		14. MOTHER'S MAIDEN NAME Nolan (Lanola)	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Geraldine Lith. Gaithersburg. Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 002 X DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause as Bronchitis DUE TO (c) Bronchitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a m 19 p m		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 58 19 to Dec 21 19 60 that I last saw the deceased alive on Dec 21 19 60 , and that death occurred at 7 A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Gaithersburg Md. DATE SIGNED Luciano I. Leal			
ACTUAL SIGNATURE Luciano I. Leal M.D.		PHYSICIAN'S NAME (Type) Luciano I. Leal	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-60	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. ADDRESS Gaithersburg. Md.		24a. REC'D BY REGISTRAR DEC 27 1960	24b. REGISTRAR'S SIGNATURE Arthur E. Thomas

14031
14045
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7025 EASTERN AVE.</u>				e. STREET ADDRESS <u>7025 EASTERN AVE</u>			
3. NAME OF DECEASED (Type or print) <u>HARRIETT</u> First <u>M.</u> Middle <u>GRAYBILL</u> Last				4. DATE OF DEATH <u>DEC.</u> Month <u>20</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. RUBEL</u>				14. MOTHER'S MAIDEN NAME <u>GILLIAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mac Ruth R.G. Hall, 7025 Eastern Ave</u> Address <u>TAK PR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>full minute</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/8, 1960</u> , to <u>12/19, 1960</u> , that (I) (we) last saw the deceased alive on <u>12/19, 1960</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Coleman MD.</u> M.D.				22b. DATE SIGNED <u>12/24/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>				22d. ADDRESS <u>733 Sleigh Avenue, Silver Spring MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>DEC 21, '60</u>		<u>MT HOPE CEMETERY</u>		<u>MARLETON IOWA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Coleman</u> ADDRESS <u>WASH DC 254 Carroll St NW</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE <u>DEC 23 '60</u>			



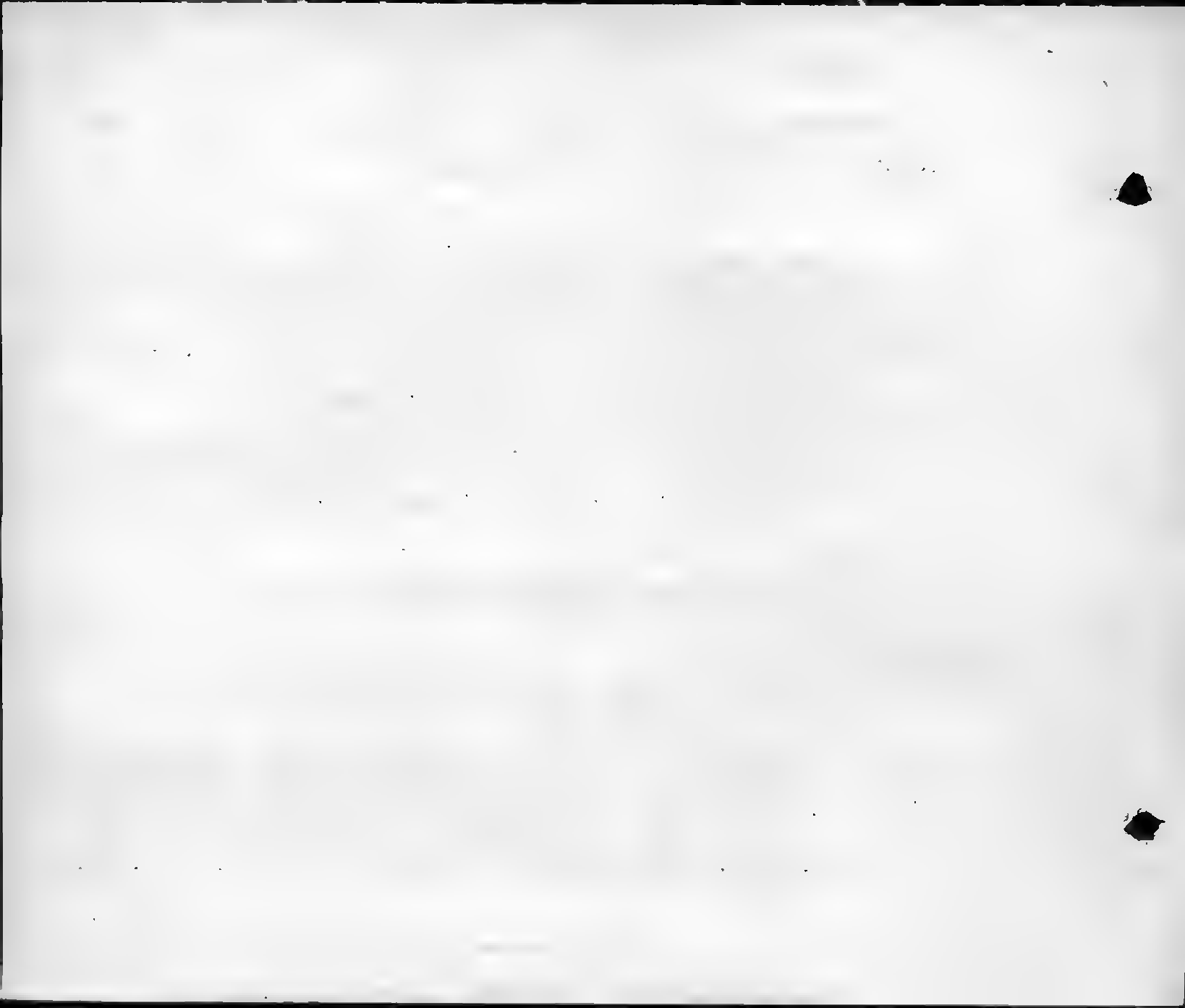
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14122

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14046

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5924 Johnson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Jacqueline Middle V Last Grosso		4. DATE OF DEATH Month 12 Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 14 Hours 15 Min 60	11. IF UNDER 24 HRS. Months 77 Days 14 Hours 15 Min 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Sicily		12. CITIZEN OF WHAT COUNTRY? US-Naturalized	
13. FATHER'S NAME James Vaiana		14. MOTHER'S MAIDEN NAME Mary Ferrara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Henson, Daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease (c) Chronic Phlebitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 12/14 1960, that (I) (we) last saw the deceased alive on 12/13 1960, and that death occurred at 3 P. M. from the causes and on the date stated above			
22a. SIGNATURE William T. Joyce		22b. DATE SIGNED 12/14/60	
22c. PHYSICIAN'S NAME (Type) William T. Joyce		22d. ADDRESS 8106 Maple Ridge Rd. Beth. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/17/60	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City, town or county) (State) Nesquehoning, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REG STRAR DATE DEC 20 '60 25b. REGISTRAR'S SIGNATURE C. Stuart S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14032

CERTIFICATE OF DEATH

14047

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (outside corporate limits write RURAL and give nearest town)

Takoma Park, Md. D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium Hosp. 2220 Washington Ave.

3. NAME OF DECEASED

(Type or print)

Alexander Herbert Grolman

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

☒ NEVER MARRIED

8. DATE OF BIRTH

2-22-91

9. AGE (In years last birthday)

69 yrs.

12. CITIZEN OF WHAT COUNTRY

USA.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Mens Wear

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Isaac Grolman

14. MOTHER'S MAIDEN NAME

Emma Deutsch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

519-01-1730

17. INFORMANT

Ira Grolman Same Address

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

42.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

Acute Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

1 Hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

0

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY

Hour a.m.

p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that (I) (this hospital) attended the deceased from 12/25/1960 to 12/25/1960, that (I) (we) last saw the deceased alive on 12/25/1960, and that death occurred at 9:45 PM, from the causes and on the date stated above.

22a. SIGNATURE

James L. Laubach

22c. PHYSICIAN'S NAME (Type)

JAMES L. LAUBACH, M.D.

ATTENDING PHYS

☒

MED. DIRECTOR

☐

STAFF PHYS.

☐

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

12-27-60

23c. NAME OF CEMETERY OR CREMATORY

NAT'L. MEM. PARK

23d. LOCATION (City, town or county)

FALLS CHURCH, VA.

24. FUNERAL DIRECTOR'S SIGNATURE

Goodberg Funeral Home

ADDRESS

4217-9th Ave DE

25a. REC'D BY REGISTRAR

DEC 28 '60

25b. REGISTRAR'S SIGNATURE

Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Coroner of Mont Co - Dr Frank Proschy notified asked Dr James Laubach to sign certificate



1
FOR STATE
HEALTH DEPT.

THIS MEDICAL EXAMINEE This certificate should be completed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 14 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 804 Thayer Ave

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE md b. COUNTY monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 804 Thayer Ave

3. NAME OF DECEASED (Type or print) MAUD L. GUNN
4. DATE OF DEATH Dec 23 1960

5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 4-29-1896
WIDOWED ☐ DIVORCED ☐ 9. AGE (in years if UNDER 1 year; if UNDER 24 HRS. last birthday) 70 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME 11. BIRTHPLACE (State or foreign country) va 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME FRANK SHERMAN 14. MOTHER'S MAIDEN NAME ANNIE JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Sam. L. Gunn Jr

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Thrombosis
DUE TO (b) Cerebral Dissection
DUE TO (c) Fractured Skull
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Sudden
INTERVAL BETWEEN ONSET AND DEATH Sudden

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reputed beaten with an iron pipe

20c. TIME OF INJURY Month, Day, Year 12-23-60 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Silver Spring (County) Monty (State) md

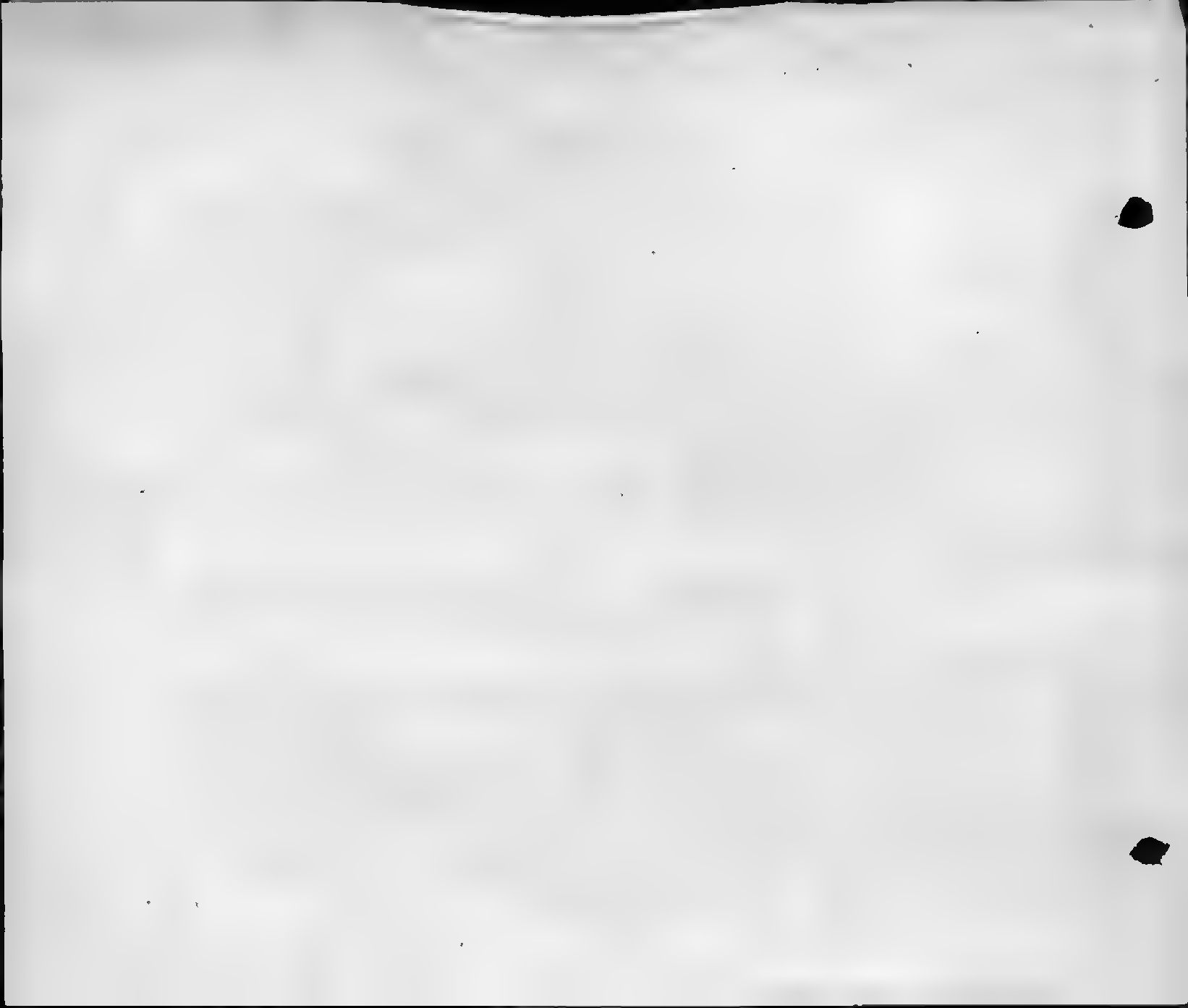
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Bloeschant M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S (Type) FRANK J. Bloeschant DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 12-24-60

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 12/27/60 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY 22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR Walter E. Humphrey Inc. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR DEC 29 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

2



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14849

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 4510 Baltimore Ave.			
3. NAME OF DECEASED (Type or print) First Nels Middle HAGE Last HAGE				4. DATE OF DEATH Month December Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-86	9. AGE (In years last birthday) 74 yrs.	10. UNDER 1 YEAR Months 7 Days 4 Hours 15 Min 00		11. UNDER 24 HRS Hours 15 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Nels Hage			
14. MOTHER'S MAIDEN NAME Sigri Hanstotter				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, Bethesda, Md.	
20f. (City or town) Bethesda				20g. (County) Prince Georges		20h. (State) Md.	
21. I certify that U (this hospital) attended the deceased from Dec. 20, 1960 to Dec. 21, 1960 that U (we) last saw the deceased alive on Dec. 21, 1960 , and that death occurred at 2:35 AM from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				22b. DATE SIGNED 12-21-60		22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Son				25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Knecht	
24. ADDRESS Gasch's Funeral Home, Hyattsville, Md.							

X

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14124

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14050

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 1-5-2			
3. NAME OF DECEASED (Type or print) First HERBERT Middle ELMER Last HALL				4. DATE OF DEATH Month DECEMBER Day 27 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/1884		9. AGE (in years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CAR DEALER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN HALL				14. MOTHER'S MAIDEN NAME JANE PHAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertensive Cardiovascular Disease (b) Yrs (c) Yrs PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 56 to 12/27 , 19 60 , that (I) (we) last saw the deceased alive on 12/27 , 19 60 , and that death occurred at 1000 M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/60	
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MD.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery Highland, Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Hamilton, Laurel, Md				25a. RECEIVED BY REGISTRAR JAN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	



1
FOR STATE
HEALTH DEPT.

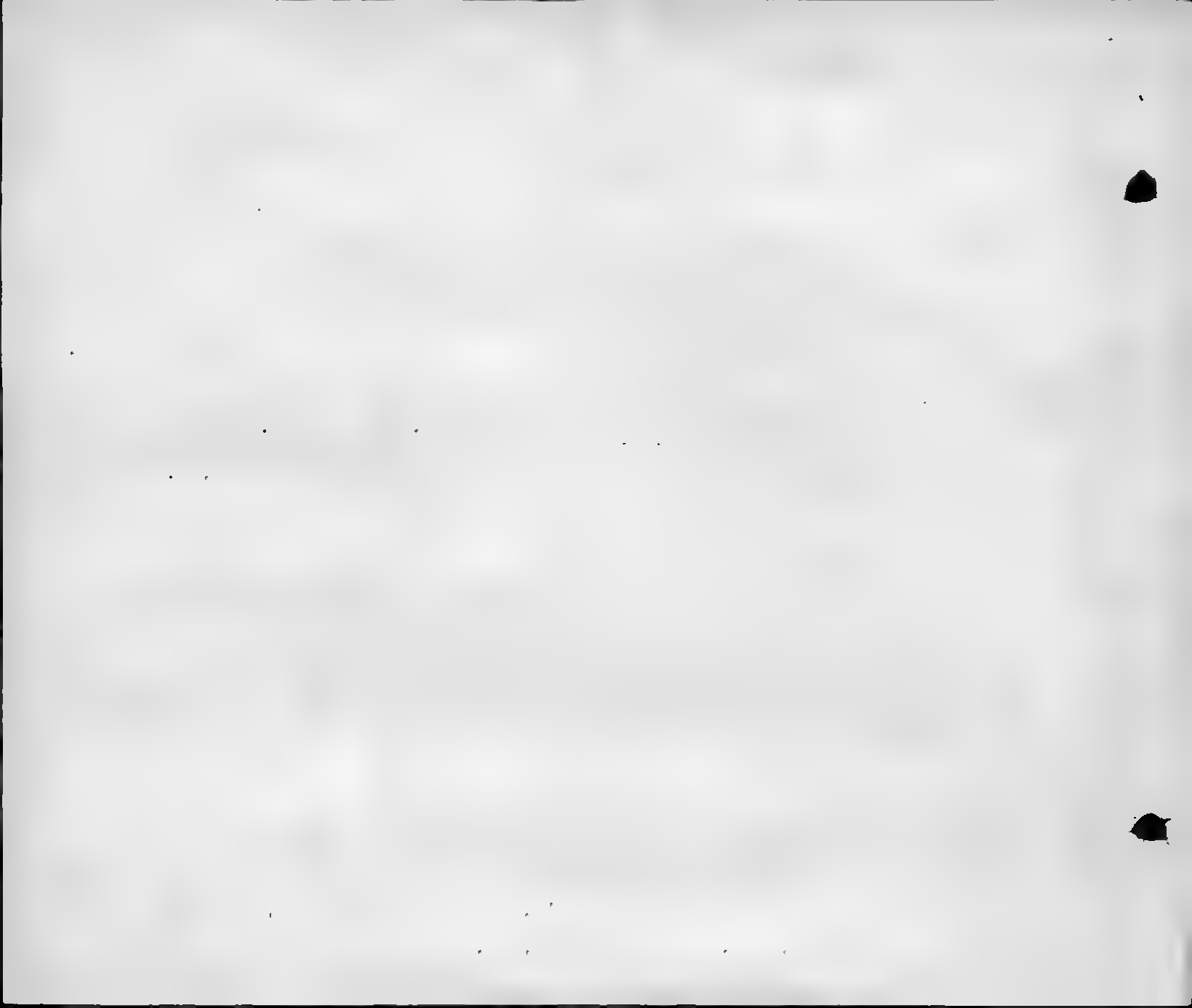
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
140365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14051

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanit Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>514 Cannon Rd</u>	
3. NAME OF DECEASED (Type or print) <u>GAIL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/02</u> 9. AGE (In years last birthday) <u>58</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trunk Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Per</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED W. HAMNER</u>		14. MOTHER'S MAIDEN NAME <u>CORA HITCHCOCK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>577-09-3536</u>		17. INFORMANT <u>Mrs. Catherine F. Hamner</u> <u>514 Cannon Road</u> <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Coronary occlusion</u> (b) DUE TO <u>4201</u> (c) DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschank</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschank</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frawls</u>		DATE SIGNED <u>12-12-60</u>	



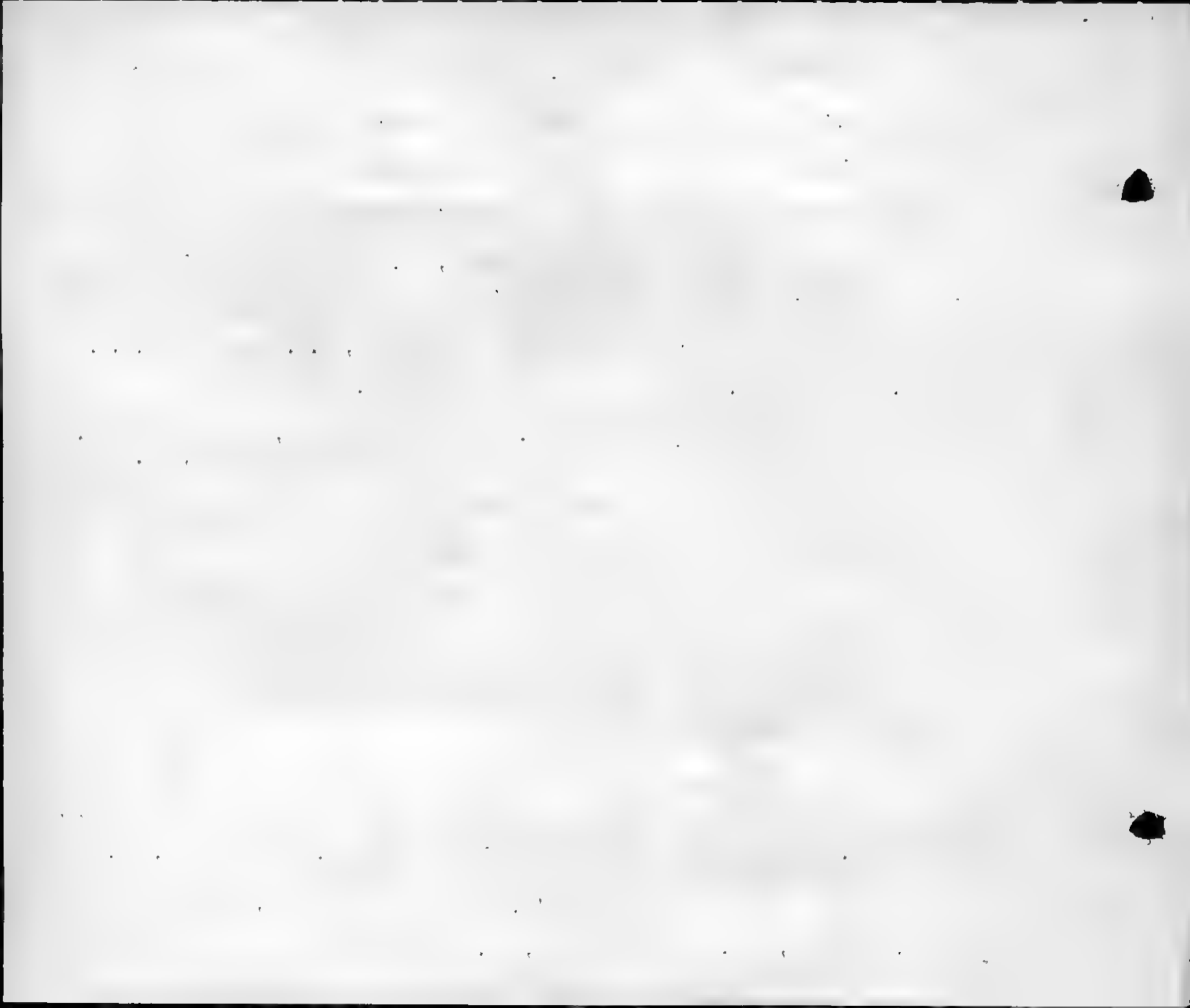
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14052

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 STIRLING ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANCIS Last HANRAHAN, JR.				4. DATE OF DEATH Month DECEMBER Day 17 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/96	
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 1 Min 0		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN (Woodward & Lothrop)				10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL			
13. FATHER'S NAME JAMES F. HANRAHAN, SR.				14. MOTHER'S MAIDEN NAME NETTIE M. DOVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 577-01-4765		17. INFORMANT Address Mrs. Mary Agnes Hanrahan, 505 Stirling Rd. Silver Spring, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO (c) Heart Failure							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 16 19 60 , to Dec 17 19 60 , that (I) (we) last saw the deceased alive on Dec 17 19 60 , and that death occurred at 4 M, from the causes and on the date stated above							
22a. SIGNATURE J. Raymond Ready				22b. DATE SIGNED 12/17/60			
22c. PHYSICIAN'S NAME (Type) J. RAYMOND READY				22d. ADDRESS 3701 LELAND ST., CHEVY CHASE, MD.			
23a. BURIAL CREMATION, REMOVA. (Specify) BURIAL		23b. DATE THEREOF 12/21/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DEC 27 '60	
25b. REGISTRAR'S SIGNATURE W. E. Pumphrey							



1

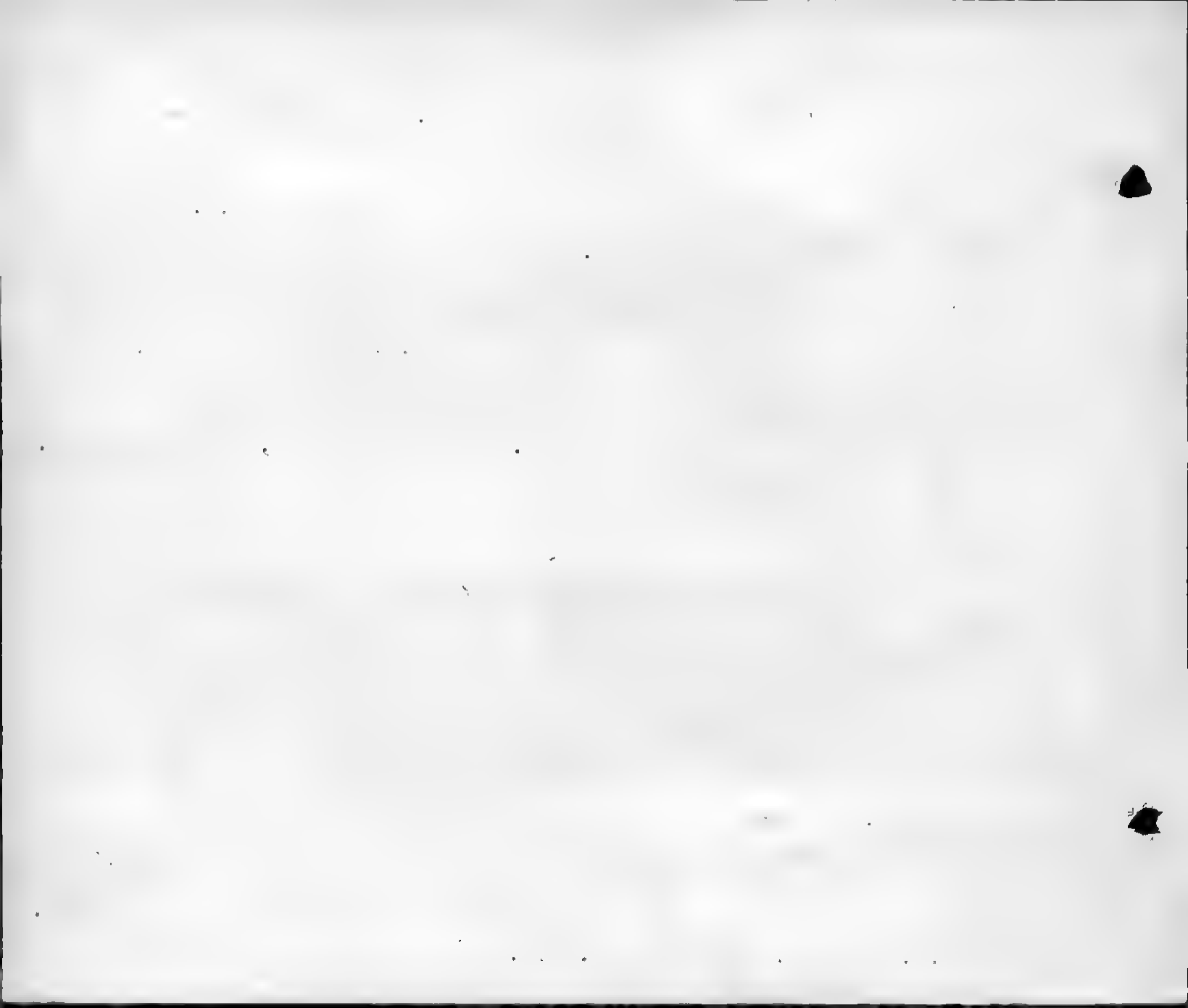
M

1

<div style="text-align: center;"> CERTIFICATE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> 14125 <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND </div> </div> <div> 14053 </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission, a. STATE D.C. b. COUNTY --							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1623 Roxanna Road, N.W.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vivia Middle V. Last Harper				4. DATE OF DEATH Month December Day 5, Year 1960							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1876		9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaiah Wood						14. MOTHER'S MAIDEN NAME Elizabeth Hill					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Elizabeth Sellman, 1623 Roxanna Rd. NW					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: (b) PROGRESSIVE MYOCARDIAL DECOMPENSATION, 3 das. (c) CORONARY SCLEROTIC HEART DISEASE 15+ yrs.										INTERVAL BETWEEN ONSET AND DEATH --	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS WITH UREMIA										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18,)							
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a m p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1947 19 to Dec. 5, 1960 , that (I) (we) last saw the deceased alive on Dec. 4, 1960 , and that death occurred at 3 AM , from the causes and on the date stated above.											
22a. SIGNATURE JAMES W. LONG M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 5, 1960			
22c. PHYSICIAN'S NAME (Type) JAMES W. LONG						22d. ADDRESS 6601 - GREENTREE RD. BETH. MD.					
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town or county) (State) Prince Georges County, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,						ADDRESS Wash, D.C.		25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE C. S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14034

CERTIFICATE OF DEATH

14054

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. c. LENGTH OF STAY IN b. 100 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 1018 Heather Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hamilton Harding Harrison First Middle Last Male White WIDOWED 4-22-81 Retired - D.C. Fire Department		4. DATE OF DEATH December 20 1960 Last Month Day Year 9. AGE (In years last birthday) 79 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTH PLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1493.3 DUE TO Varicella collapse and asystole 30 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Surgery for brain tumor (c) left frontal malignant brain tumor 6 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: no		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 12/12/60 to 12/20/60 that (I) (we) last saw the deceased alive on 12/20/60 and that death occurred at 2:00 P.M. from the causes and on the date stated above. 22. SIGNATURE John T. Lord M.D. 22c. PHYSICIAN'S NAME (Type) John T. Lord 22d. ADDRESS 1015 Spring St. Silver Spring, Md. 22e. DATE SIGNED 12/20/60 23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 12/24/60 23c. NAME OF CEMETERY OR CREMATORY Carmel Methodist Church - Kinsale, Westmoreland Co. Virginia 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. - Washington 9, D.C. 25a. REC'D BY REGISTRAR DEC 23 '60 25b. REGISTRAR'S SIGNATURE Charles E. Frank	

Reported to and approved by Montgomery County
Medical Examiner. 12-20-60 -- 3:00 P.M.

John T. Lord, MD
12-20-60

CERTIFICATE OF DEATH

Reg. Dist. No.

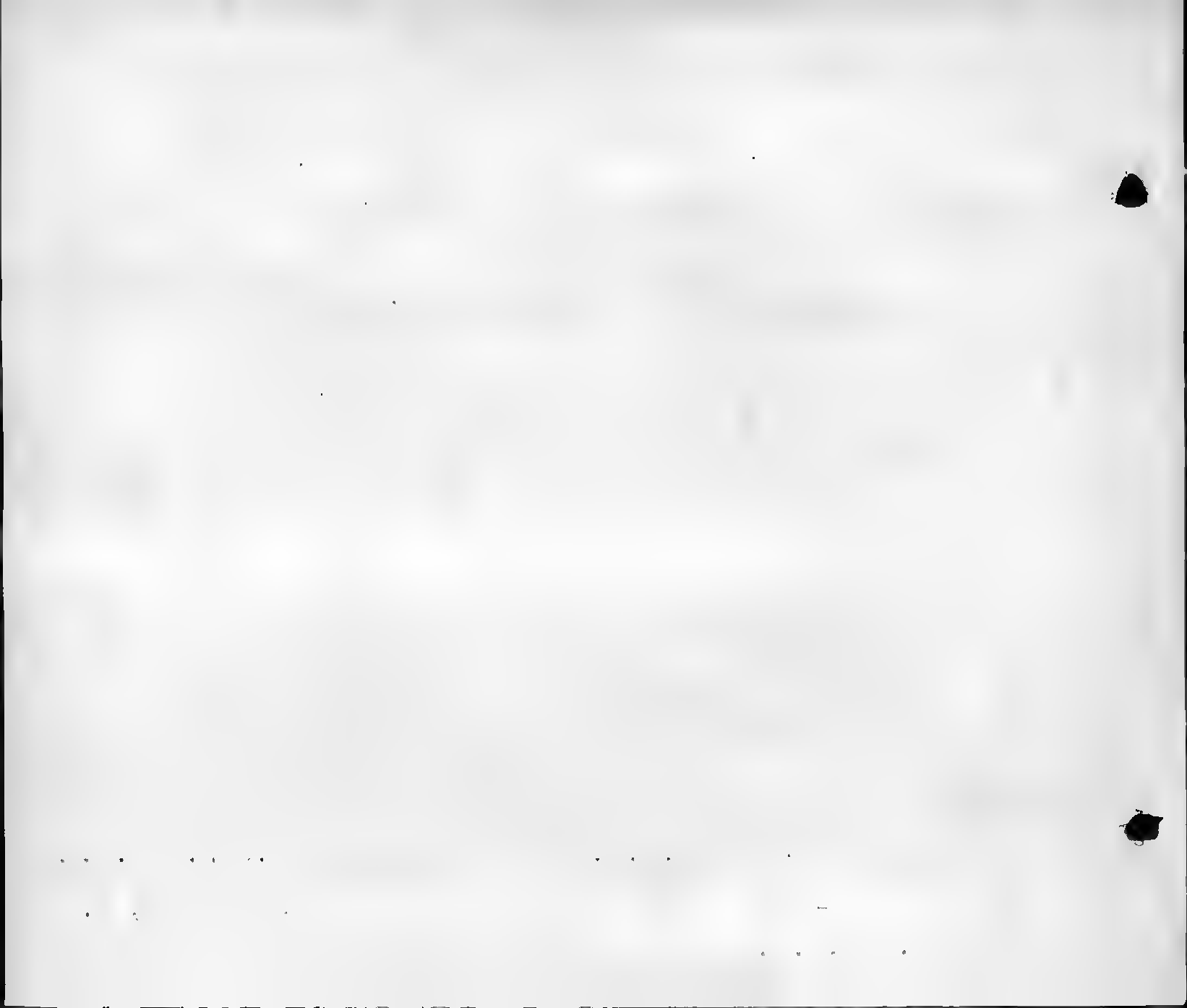
14055

14035

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. STREET ADDRESS 121 Whitmoor Terrace			
3. NAME OF DECEASED (Type or print) First Middle Last Hart				4. DATE OF DEATH Month Day Year December 14 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1960	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country)		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Humes Houston Hart				
14. MOTHER'S MAIDEN NAME Laura Carter Rouse			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO			17. INFORMANT father				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pulmonary atelectasis, very severe							INTERVAL BETWEEN ONSET AND DEATH since birth
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 14, 1960 to Dec 14, 1960 , that I last saw the deceased alive on Dec 14, 1960 , and that death occurred at 7:55 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Elizabeth Chickering M.D.							
PHYSICIAN'S NAME (Type) Elizabeth Chickering, M.D. 3601 Connecticut Ave., N.W. Wash. D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City town or county) (State)	
Cremation		12-14-60		Washington Sanitarium and Hospital, Takoma Park, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Washington Sanitarium and Hospital				24a. REC'D BY REGISTRAR DEC 19 1960		24b. REGISTRAR'S SIGNATURE Wm S. Fennell	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS AIS (4)
ISM 9/5B



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>40 min.</u>		d. STREET ADDRESS <u>7914 - 15th Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank I. Hawa</u>		4. DATE OF DEATH <u>Dec. 12 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25 1886</u>
9. AGE In years last birthday <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bagdad Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Isadore Hawa</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-15-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSIDE - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY & SONS - 3501-14th Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 20 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>- S. Thoma</u>	

12-12-60



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

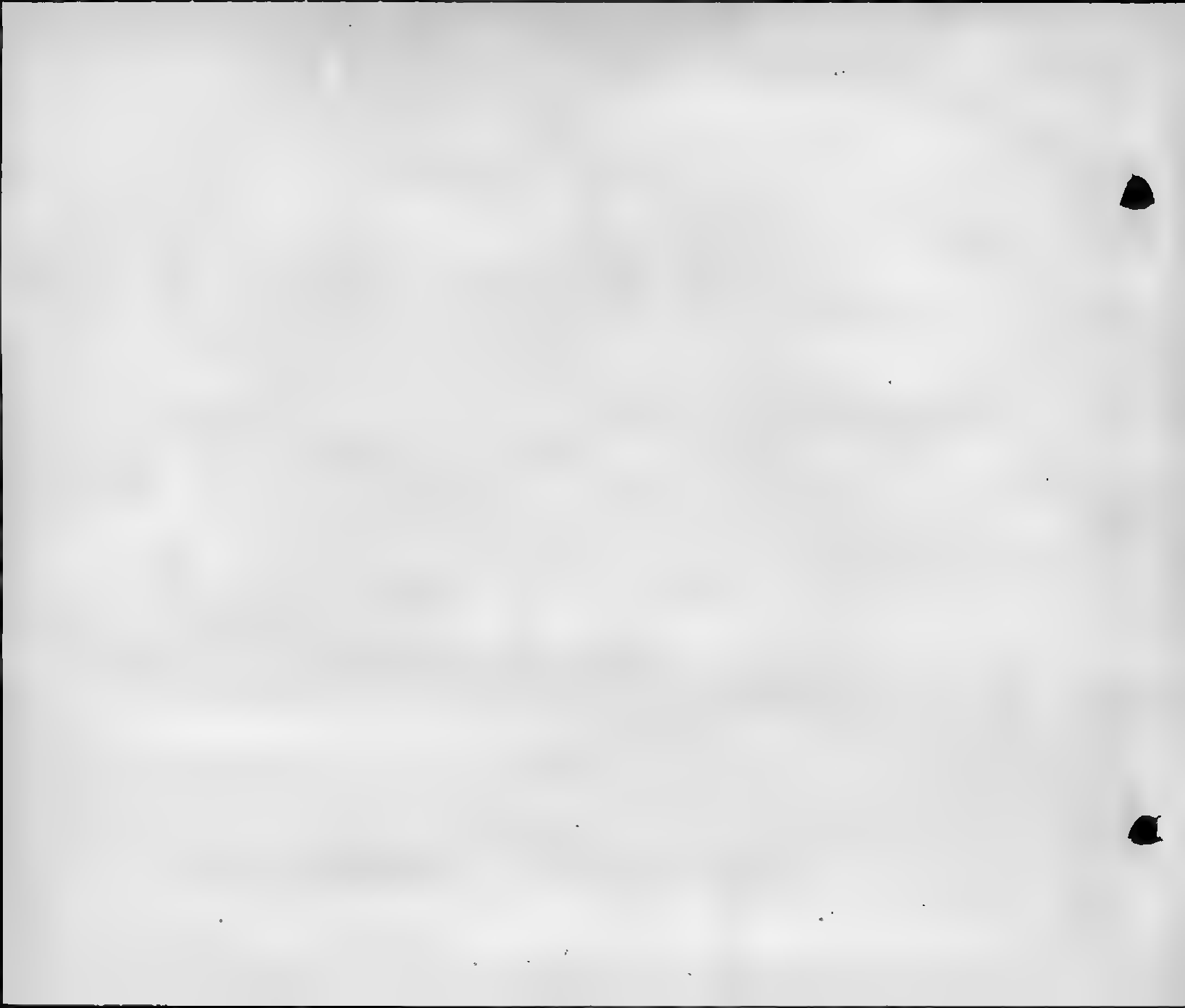
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14058

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if last full year; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (R.F.D.)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg R.F.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Burnt Hills Ref</u>		d. STREET ADDRESS <u>Burnt Hills Ref</u>	
3. NAME OF DECEASED (Type or print) <u>Colethia Denise Hawkins</u>		4. DATE OF DEATH <u>Dec 28 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Hamilton A. Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Madelaine Hebron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Madelaine Hawkins</u>		Address <u>Ston 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn involving entire body, head & extremities</u> DUE TO (b) <u>Fire of home</u> DUE TO (c) <u>Fire of home</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Chamberlain when house burned</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:45 p.m. 12-28 1960</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Clarksburg Montg md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Franz J. Broschack</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschack</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 31, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		22d. LOCATION (City, town, or country) <u>Pardum, Md.</u> (State)	
23. FUNERAL DIRECTOR <u>William L. ...</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

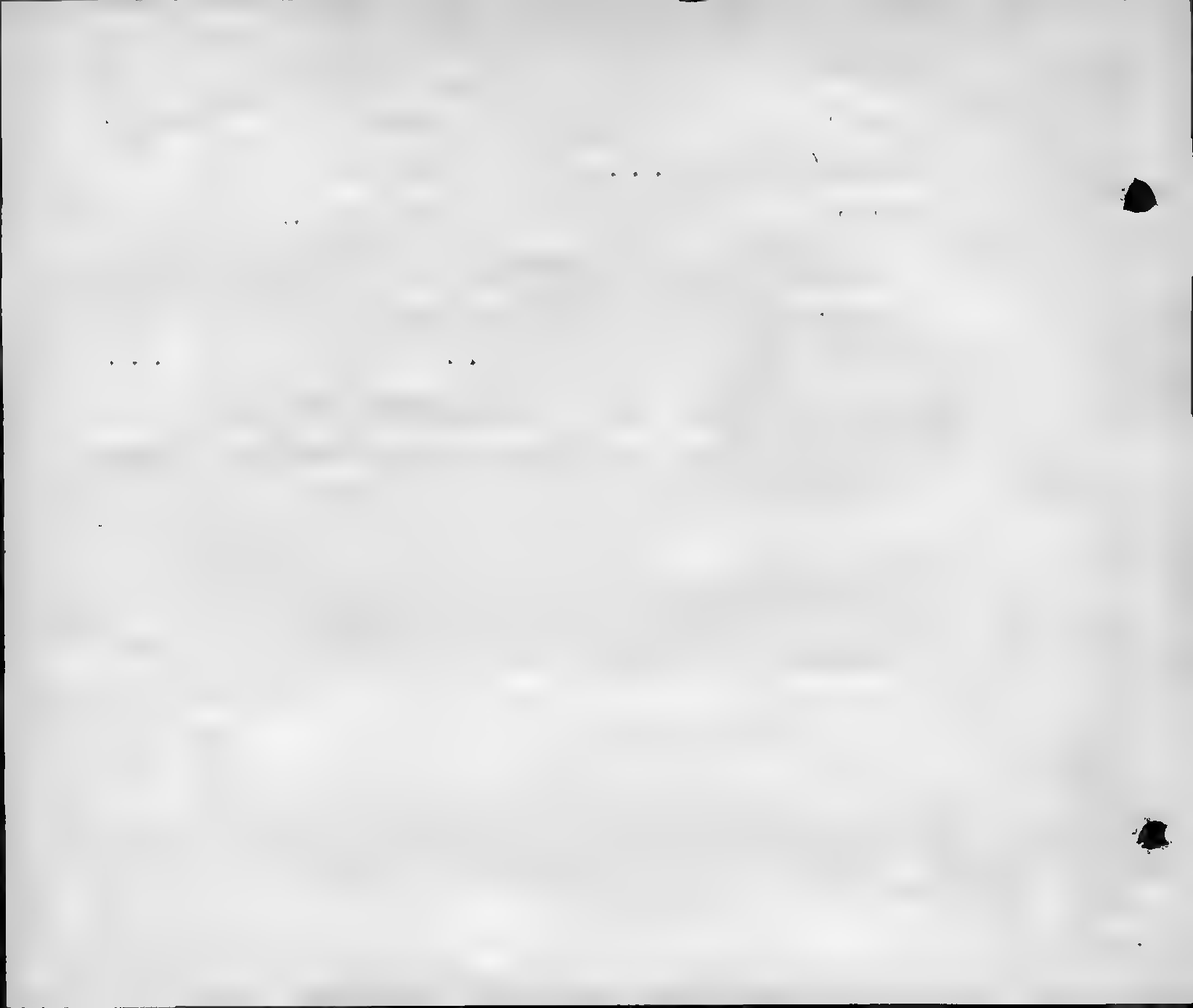
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14059

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John Bethesda D.O.A.</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>19 Carver Rd.,</u>			
3. NAME OF DECEASED (Type or print) <u>Ethel Mae Henderson</u>				4. DATE OF DEATH <u>12 29 19 60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/12/23</u>	
9. AGE (in years; if under 1 year, if under 24 hrs last birthday) <u>37</u> yrs.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tate</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>William Henderson (husband) same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Fat Embolism</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic Fatty Metamorphosis,</u> DUE TO (c) <u>Intentional</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Suburban</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1-4-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>				22d. LOCATION (City, town, or county) (State) <u>Washington - D.C.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>			
ADDRESS <u>Rockville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)
15M 9/55

14036

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14060

See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN TB Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, 23 d. STREET ADDRESS Apt. 101 13 Manchester Pl. Wayne Apts. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert		4. DATE OF DEATH Month Day Year December 12, 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1960
9. AGE (In years last birthday) — yrs.		10. IF UNDER 1 YEAR Months Days Hours Min — 6 — —	11. IF UNDER 24 HRS. Months Days Hours Min — 6 — —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Takoma Park, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mitchell Herbert		14. MOTHER'S MAIDEN NAME Patricia Mary Hannell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. ADDRESS		17. INFORMATION	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 76x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Winston E. Cochran M.D. 227 Pershing Dr., Silver Spring, Md. PHYSICIAN'S NAME (Type) Winston E. Cochran, M. D. same as above.....			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-13-60	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital		24a. REC'D BY REGISTRAR DEC 15 1960	
24b. REGISTRAR'S SIGNATURE W. L. H. Hare		24c. REGISTRAR'S SIGNATURE	

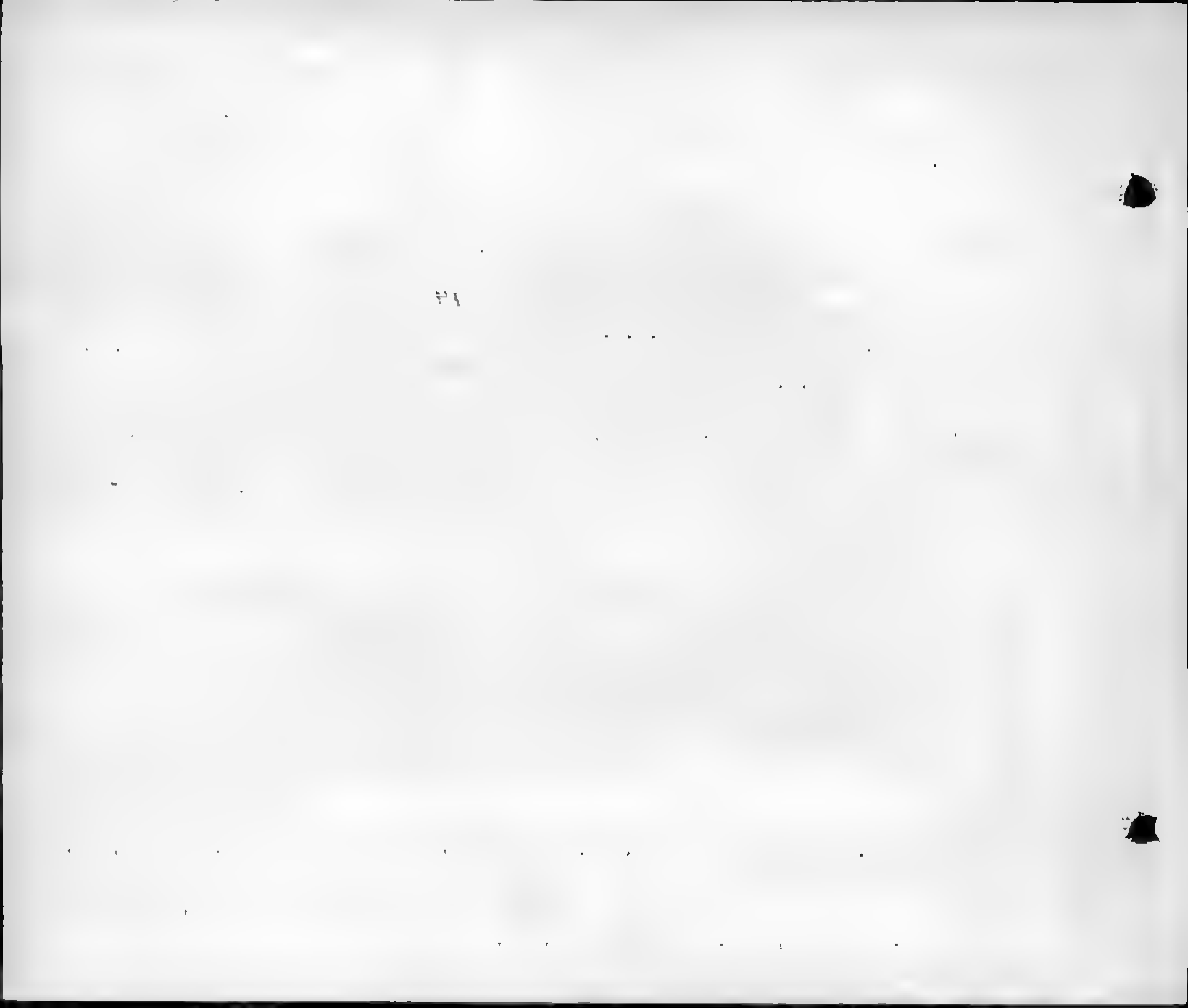
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14130

14061

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4925 Chase Church Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Daniel</u> Last <u>Herder</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G.S. Herder</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>402-05-4567</u>		17. INFORMANT <u>Lucille Herder (wife)</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>445X</u> IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u> DUE TO <u>MASSIVANT ARTERIAL HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 mos +</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>14 DEC., 1960</u> , that (I) (we) last saw the deceased alive on <u>14 DEC., 1960</u> , and that death occurred <u>6:50 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Marshall Cuvillier, Jr. M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>14 DEC. 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. MARSHALL CUVILLIER, JR.</u>				22d. ADDRESS <u>1407 Woodside Pkwy, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/17/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC. SILVER SPRING, MD.</u> <u>Raymond A. Jones</u>				25a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



14131

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14062

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clary</u>				c. LENGTH OF STAY IN <u>2702 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brocke Home Foundation Inc.</u>				d. STREET ADDRESS <u>8208 Reisterstown Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First <u>Lodge</u> Middle <u>Hill</u> Last				4. DATE OF DEATH <u>Dec.</u> Month <u>22</u> Day <u>1960</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wht.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN (retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Round Hill Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Hill</u>				14. MOTHER'S MAIDEN NAME <u>SARAH LODGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>579-38-3669</u>		17. INFORMANT <u>Mrs Ernest L. Hill</u> Address <u>8208 Reisterstown Ave</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Varicella pneumonia</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Senile degeneration of heart</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6, 1960</u> to <u>Dec 22, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 22, 1960</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>John B. Ziegler M.D.</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>				22d. ADDRESS <u>OLNEY, MARYLAND</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimpsey Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 29 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Alvin L. Pimpsey</u>	

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14063

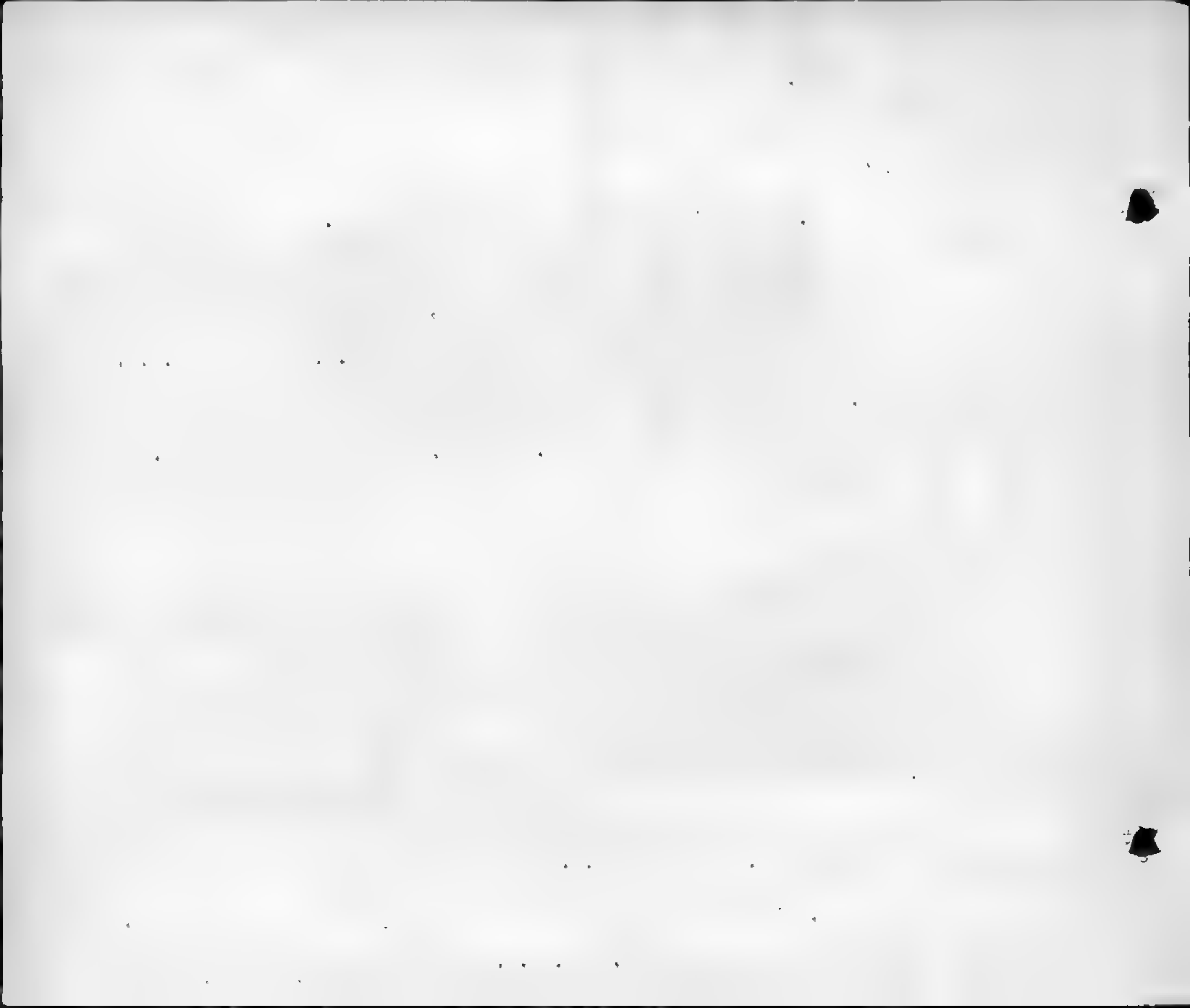
Reg. Dist. No.

14037

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tokoma Park</u>		c. LENGTH OF STAY IN 1b <u>4</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sant. Hospital</u>		e. STREET ADDRESS <u>12712 Feldon St.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES V. HILLEY</u>		4. DATE OF DEATH <u>December 24</u> 19 <u>60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Statically clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charly F. Fairfax</u>		14. MOTHER'S MAIDEN NAME <u>Constance Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Doyle R. Hilley</u>		Address <u>12712 Feldon St. Wheaton</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocardial infarction</u> (c) <u>arterio sclerotic vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/22</u> , 19 <u>60</u> , to <u>12/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>60</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles M. Weber</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles M. Weber M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 29 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Va.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Deal Funeral Home</u>		ADDRESS <u>4812 Ga. Ave. D.C.</u>	
24a. REC'D BY REGISTRAR <u>302850</u>		24b. REGISTRAR'S SIGNATURE <u>302850</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

14064

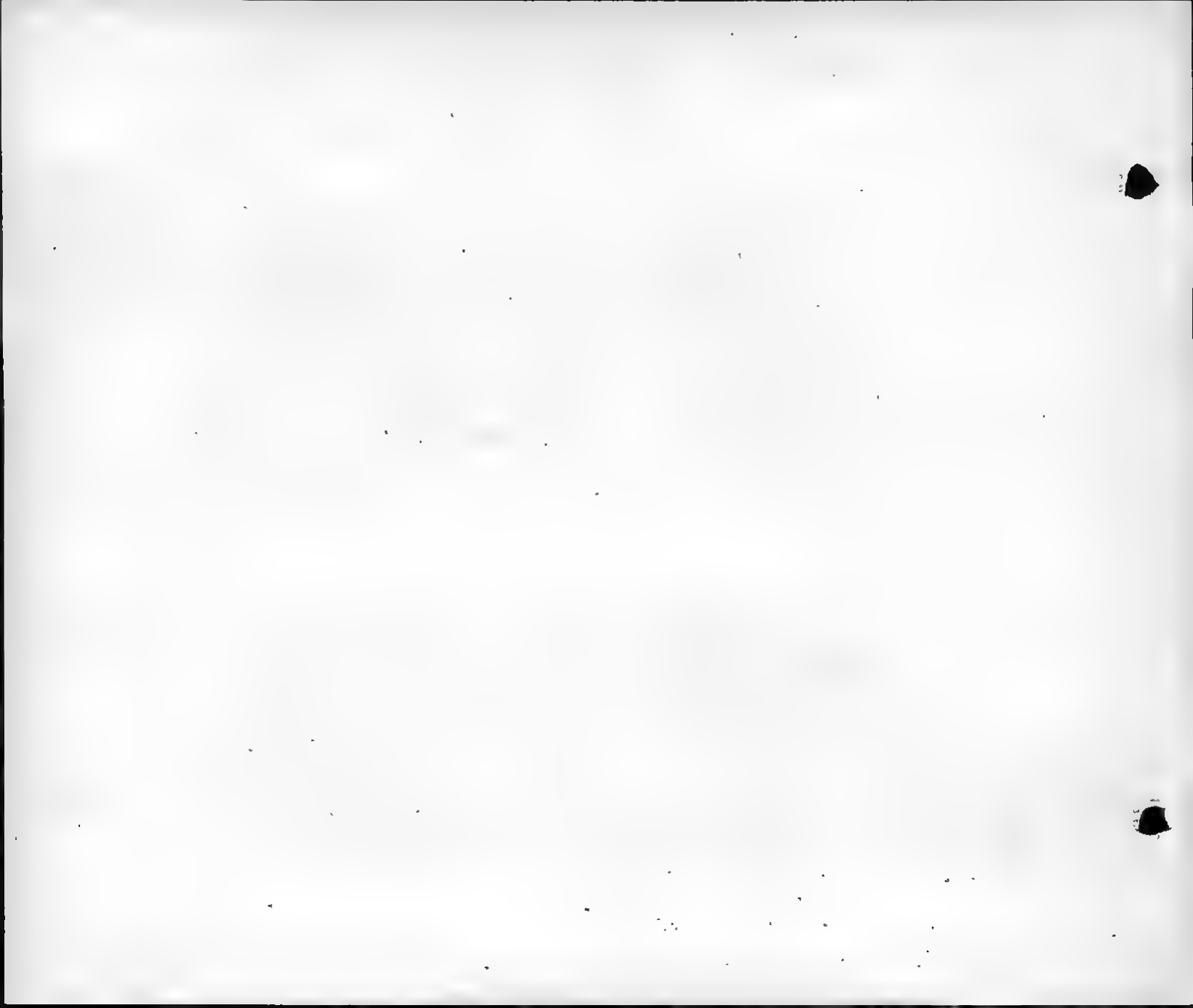
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE D.C. b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Glenn Middle D Last Hively		4. DATE OF DEATH Month December Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 15, 1913
9. AGE (In years last birthday) yrs 47		10. IF UNDER 1 YEAR Months 4 Days 7 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing		10b. KIND OF BUSINESS OR INDUSTRY West virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter A. Hively		14. MOTHER'S MAIDEN NAME Sarrah Simmons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Army		16. SOCIAL SECURITY NO. INFORMANT (wife) Mrs. Mary L. Hively Address As above	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Coronary Arteries DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 DEC 5 , 1960, that I last saw the deceased alive on DEC 4 , 1960, and that death occurred at 12:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. L. Tabb, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 13000 GEORGIA AVE - S.W. Sp. Md 11/1/60	
PHYSICIAN'S NAME (Type) Samuel L. Tabb			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/7/60		22b. NAME OF CEMETERY OR CREMATORY Elton Va.	
22c. LOCATION (City, town, or county) (State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Huntman, Son		24a. REC'D BY REGISTRAR DATE DEC 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hunt			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



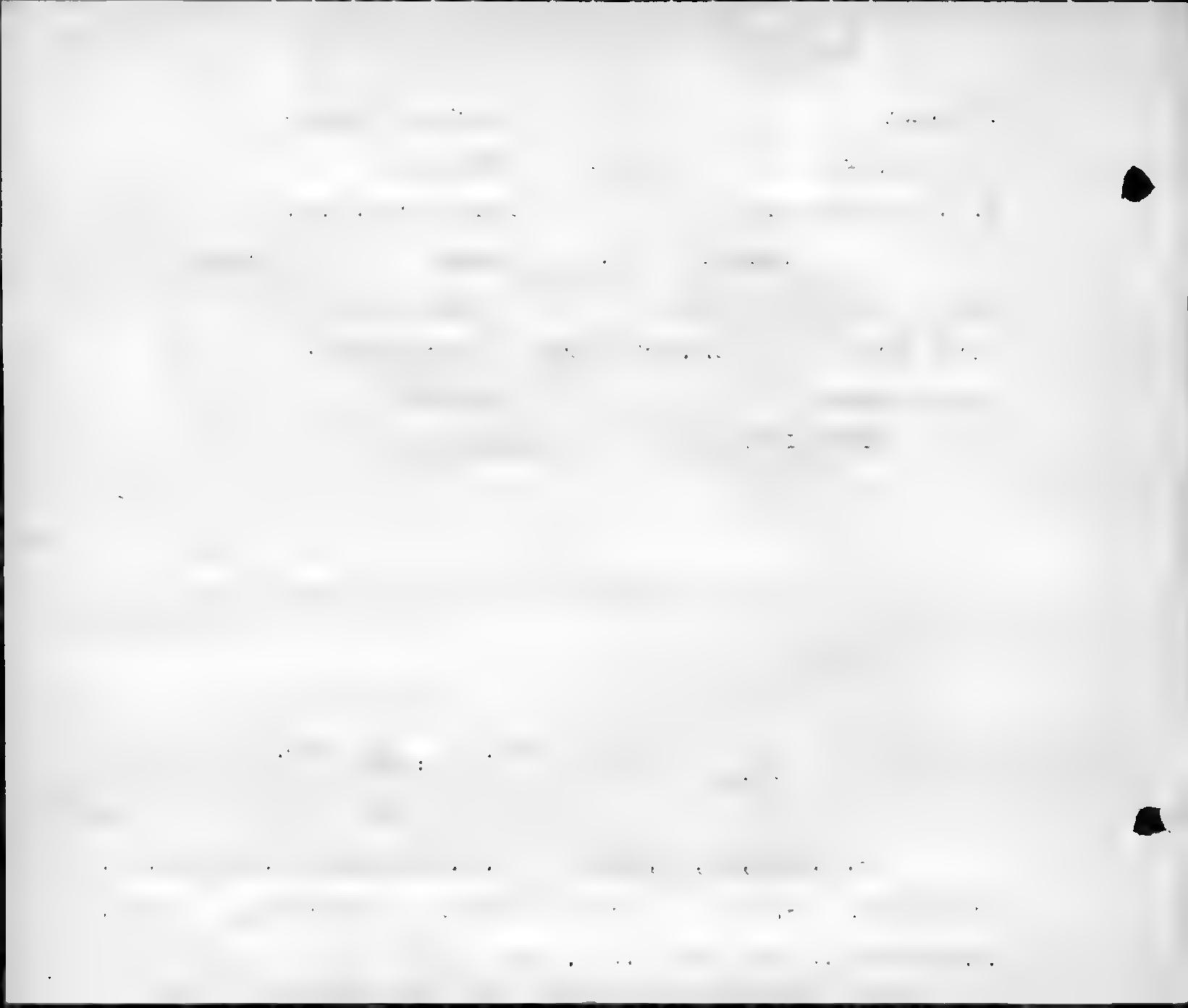
TO HOSPITAL CLERK: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

14133

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14065

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X-3 d. STREET ADDRESS 1901 K Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Reginald P. HODGDON			4. DATE OF DEATH Month Day Year December 6 19 60				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-92	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Massachusetts			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Parklin HODGDON				
14. MOTHER'S MAIDEN NAME Jenny ORNE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				
16. SOCIAL SECURITY NO 577-58-1956			17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 4 weeks		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gloucester			
20f. (City or town)		(County)		(State)			
21. I certify that (X) (this hospital) attended the deceased from Nov. 21 19 60 to Dec. 6 19 60 that (X) (we) last saw the deceased alive on Dec. 6 19 60 , and that death occurred at 9:20 PM from the causes and on the date stated above.							
22a. SIGNATURE B H Rice		22b. DATE SIGNED 12-7-60		22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT, MC, USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 12-7-60		23b. DATE THEREOF 12-7-60		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery			
23d. LOCATION (City, town, or county) Gloucester		(State) Mass.					
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR DEC 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

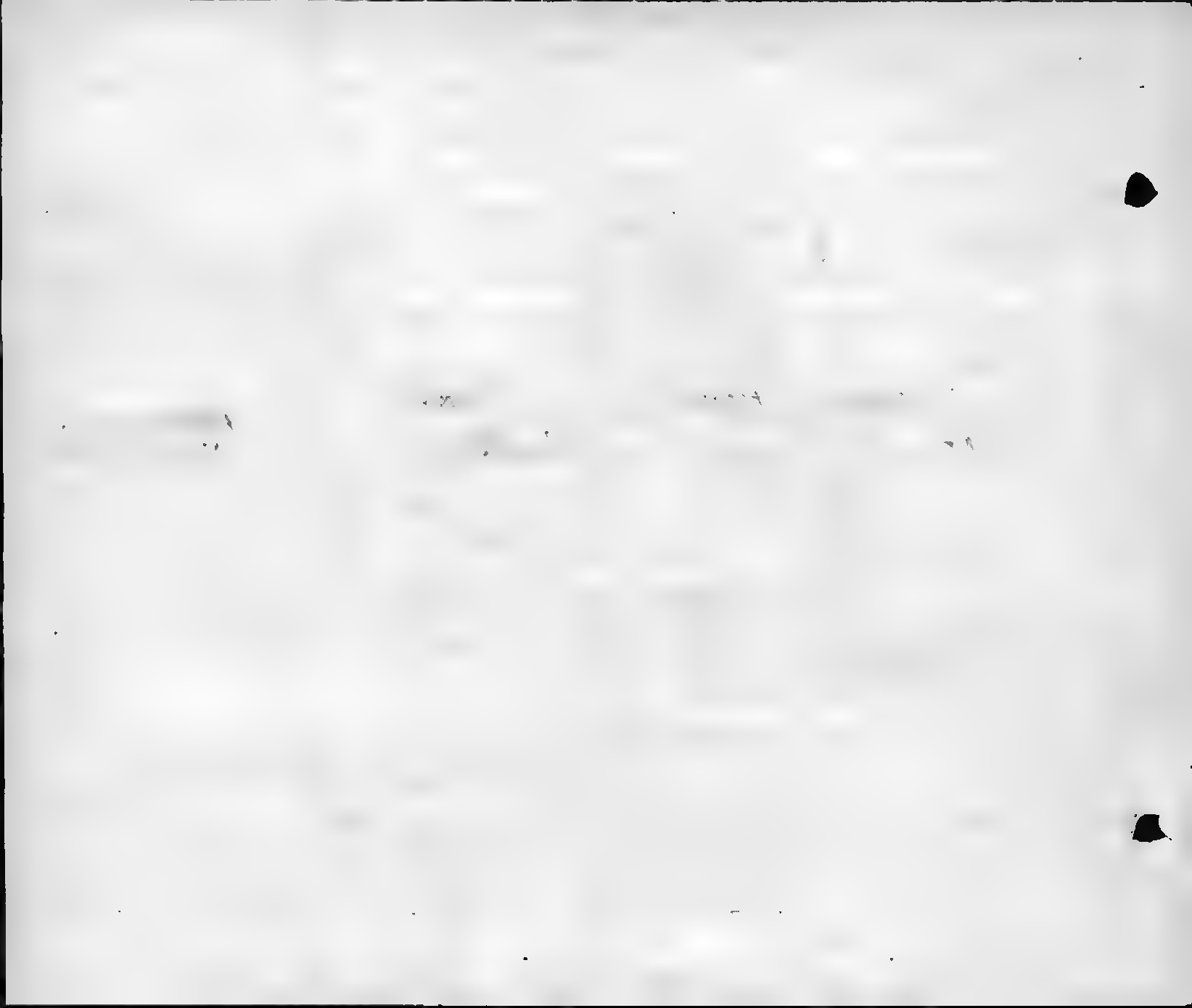
VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1413* MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>M.</u> Last <u>Hove</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont Co. Liquor Board</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>TORGER T. HOVE</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Curtis L. Hove (son)</u>		Address <u>PRATHER BRIDGER RD TOCCOA, GEORGIA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Due to</u> DUE TO (c) <u>Due to</u> cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, <u>Burial-transit</u>		22b. DATE THEREOF <u>12-24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Prairie, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hove</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14135 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14168

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martinsburg Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson</u> R.F.D. d. STREET ADDRESS <u>1 Martinsburg Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Marie Jane Hoyer</u>		4. DATE OF DEATH <u>Dec 25 1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>		9. AGE (In years if UNDER 1 YEAR; If UNDER 24 HRS last birthday) <u>68</u> yrs.		10. MONTHS <u>12</u> DAYS <u>25</u> HOURS <u>00</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Hoyer - Dickerson, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of face with generalized metastases</u> 1960.c DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a. b. c.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		22. DATE SIGNED <u>12-25-60</u>		22a. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		22b. DATE THEREOF <u>12/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Dawsonville, Md.</u>		23. FUNERAL DIRECTOR <u>Robert L. Shander</u> ADDRESS <u>Rock</u>		24a. REC'D BY REGISTRAR <u>Jan 4 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		24c. DATE <u>JAN 4 '61</u>		24d. REGISTRAR'S SIGNATURE		24e. DATE	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14136 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14068

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>			d. STREET ADDRESS <u>5821 Bradley Blvd.</u>		
3. NAME OF DECEASED (Type or print) <u>Claude T. Hunt</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>19 60</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24 1899</u>		9. AGE (in years last birthday) <u>61</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traffic Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Railway</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Charles Hunt</u>		
14. MOTHER'S MARRIEN NAME <u>Alice May Evans</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT Address <u>Elva D. Hunt-wife-same above 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>973.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Blood contained ethyl alcohol 1.1%, carbon monoxide 4.0%</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Dec 24 1960</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur R. Harris</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

14137

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14069

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 9 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POOLESVILLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 1 R-2			
3 NAME OF DECEASED (Type or print) First JAMES Middle HAROLD Last HURD				4. DATE OF DEATH Month DECEMBER Day 14 Year 1960			
5 SEX MALE		6. COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-60	
9 AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13 FATHER'S NAME HAROLD DEAN HURD				14 MOTHER'S MAIDEN NAME SHIRLEY FRANCES HURD HALE			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS OLNEY, MARYLAND			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773-5 Hyaline Membrane Disease DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Caesarian Sect. for Abruptio Placenta) DUE TO (c) 9 hrs INTERVAL BETWEEN ONSET AND DEATH 9 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from DEC 14, 1960 to DEC 14, 1960 , that (I) (we) last saw the deceased alive on DEC 14, 1960 , and that death occurred at 8:15 AM from the causes and on the date stated above							
22a. SIGNATURE 		M. D. C. H. LIGON, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS SANDY SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 14/16/60		23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City town or county) (State) Greenwood, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS E. J. Gorman, York, Md.		25a. REC'D BY REGISTRAR DATE DEC 19 1960	
				25b. REGISTRAR'S SIGNATURE C. J. Ligon			

2013212XV2

24/11/51

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15/12/51

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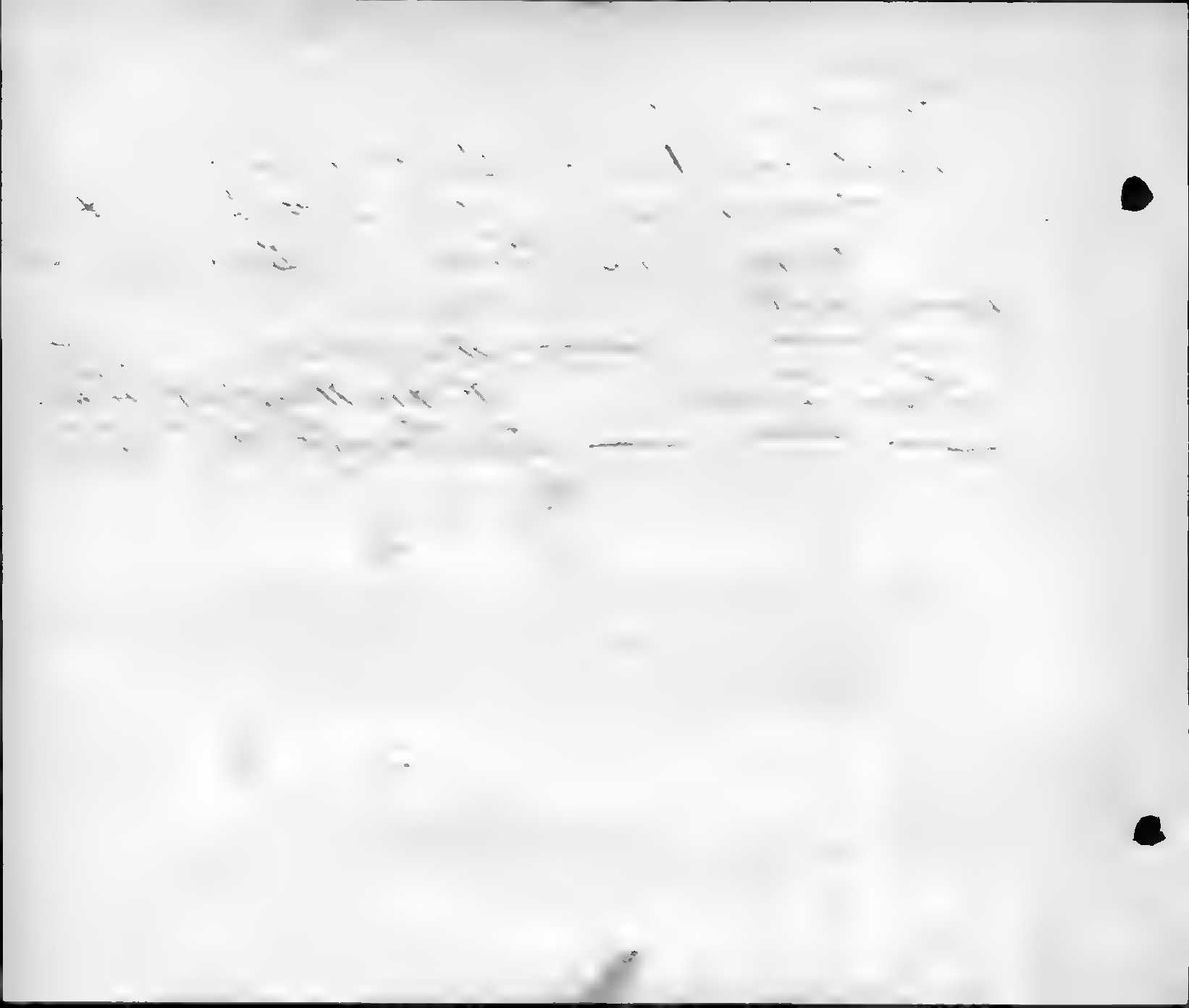
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14070

14138

1. PLACE OF DEATH a. COUNTY <i>Montgomery - MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Mt.</i>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN TB <i>49h 25M</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>1 R.F.D. # 3</i>		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Baby Girl</i> Middle <i>Imes</i> Last <i>Imes</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>27</i> Year <i>1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/26/60</i>	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
						12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Imes</i>				14. MOTHER'S MAIDEN NAME <i>Rolie May Hall / Ashmore</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>John Imes father same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>HEPATOITIS</i> DUE TO <i>762.0</i>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12-26-60</i> to <i>12-27-60</i> that (I) (we) last saw the deceased alive on <i>Dec 27 1960</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Shaw. R. Snowden</i> M.D.				22b. DATE SIGNED <i>12/29/60</i>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-31-60</i>		<i>Lincoln Park</i>		<i>Rockville, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				24b. ADDRESS <i>Rockville, Md</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 4 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and no later than 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in approval within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 13, 14 File 6278											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u>		c. LENGTH OF STAY IN b. <u>1/2 hr</u>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Monty General Hosp</u>		e. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> d. STREET ADDRESS <u>Box 41</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Allen Claude James</u> (Type or print)		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26-23</u>		9. AGE (in years last birthday) <u>37</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY?		4. DATE OF DEATH <u>Dec 27</u> 19 <u>66</u> Month Day Year		IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME <u>Ira James</u>		14. MOTHER'S MAIDEN NAME <u>Rosa QUINN</u> <u>Edith James (wife)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Item 2</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>583 X</u> DUE TO <u>acute hemorrhagic gastritis</u> Conditions, if any, which gave rise to immediate cause } (a), stating the underlying cause last } DUE TO <u>Gastritis & edema of lung</u> (c) <u>chronic passive congestion, liver</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-27-66</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/30/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Cal.</u>		22d. LOCATION (City, town, or country) <u>Clarksburg</u>		(State)			
23. FUNERAL DIRECTOR <u>Frank E. Gartner</u>		ADDRESS <u>Clarksburg</u>		24a. REC'D BY REGISTRAR <u>DAWN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					



may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14038

14072

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery cty.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>29 das</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Washington Sanitarium & Hosp</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
f. STREET ADDRESS <u>112 Lee Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Wilson</u> Last <u>James</u>		4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1864</u>
9. AGE (In years last birthday) <u>96</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America (U.S.)</u>	
13. FATHER'S NAME <u>Thomas James</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Devina</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>OR Mrs. T. E. Murray</u>		Address <u>112 Lee Ave Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO <u>Senility & Cardiac Failure</u> DUE TO <u>Early Bacteria due to Prostatic Hypertrophy</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>Senility & Early Bacteria</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22</u> 19 <u>60</u> , to <u>Dec 21</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> 19 <u>60</u> , and that death occurred at <u>8:40</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilford D. Meyers M.D.</u>		22b. DATE SIGNED <u>Dec 21, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>		22d. ADDRESS <u>8323 Haddon Dr. Takoma Park Md</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 24, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		23d. LOCATION (City or town, or county) (State) <u>Takoma Park - Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Katter</u>		25a. RECEIVED BY REGISTRAR <u> </u> DATE <u>Dec 28 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



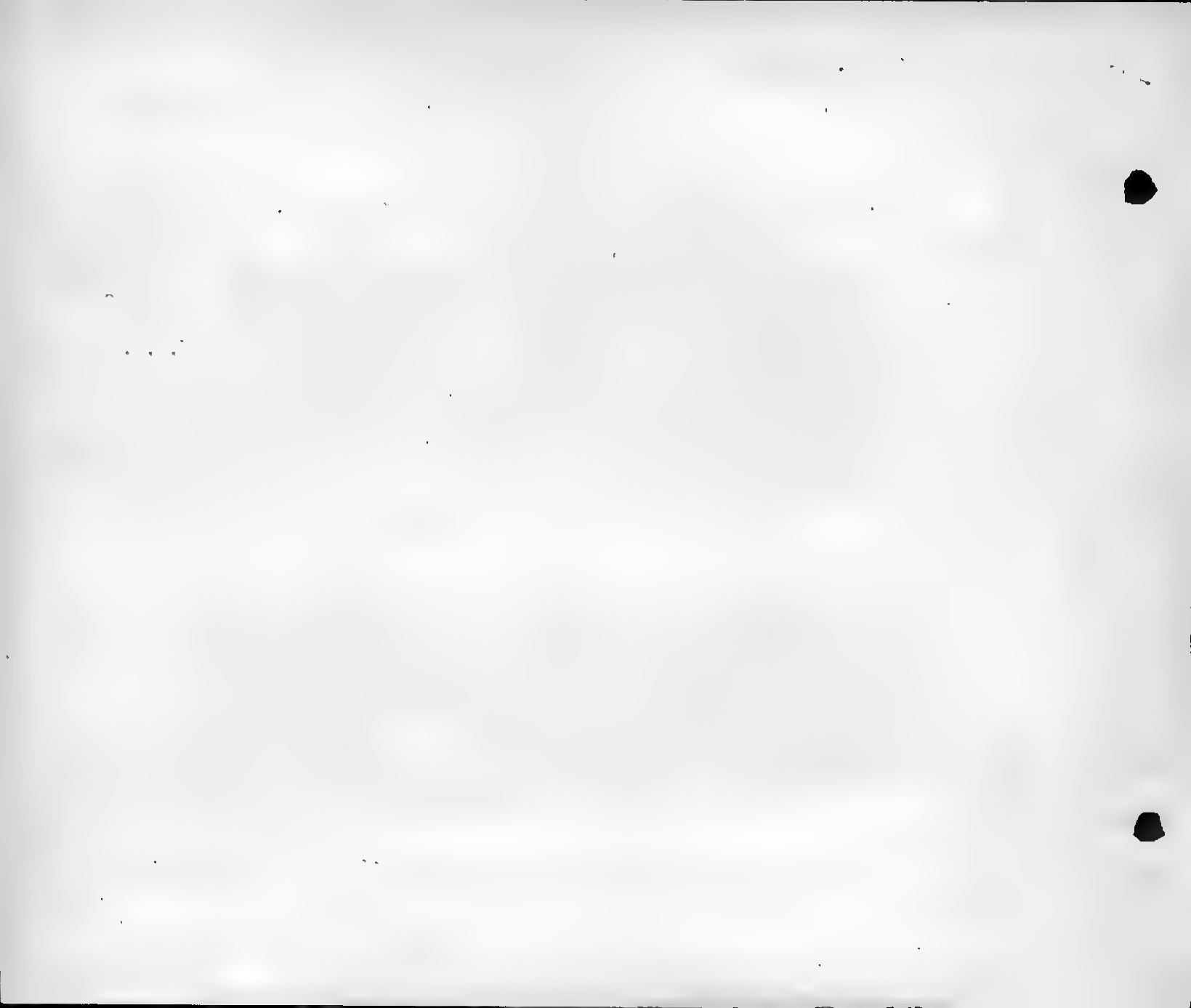
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14073

Weight 2 lbs. 14 1/4

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 322 Lincoln Ave.	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Joppy		4. DATE OF DEATH Month 12 Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/60
9. AGE (In years last birthday) 2 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Barbara Delores Joppy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Mother
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/21 19 60 to 12/21 19 60 , that (I) (we) lost saw the deceased alive on 12/21 19 60 , and that death occurred at 4:35 P. M. from the causes and on the date stated above.			
22a. SIGNATURE AURIN H MASRROD		22b. ADDRESS 521- Wisc. Ave. Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 12-27-1960	23c. NAME OF CEMETERY OR CREMATORY Suburban Hospital	23d. LOCATION (City, town or county, (State) Bethesda, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Suburban Hospital - Old Georgetown Road, Bethesda, Maryland		25a. REC'D BY REG. STRAR DATE 9 '61	25b. REGISTRAR'S SIGNATURE C. E. H. HARRIS





TO HOSPITAL ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14142

14075

1

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 77 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESNOR Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ss on) a. STATE District of Columbia b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3721 Locelyn St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NEILIE Middle VERONICA Last KEATING		4. DATE OF DEATH Month DEC. Day 19 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1893
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (UNKNOWN)		10b. KIND OF BUSINESS OR INDUSTRY PROPERTY MANAGEMENT	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME PATRICK KEATING		14. MOTHER'S MAIDEN NAME ELLEN REGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT EUGENE MULLIN Address (Nephew) 300 SOUTHERN Bldg., Wash. 5, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchopneumonia DUE TO (b) Cardio-vascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/14 1957 to 12/19 1960 , that (I) (we) lost saw the deceased alive on 12/19 1960 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John E. Everett		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT		22d. ADDRESS 9400 CONN. AVE., KENSINGTON	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-22-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Saint Cemetery	23d. LOCATION (City, town, or county) (State) Washington D.C.
24. FUNERAL DIRECTOR'S SIGNATURE H. Donahue		25a. REC'D BY REGISTRAR DEC 28 '60	
ADDRESS 2224 Wisconsin		25b. REGISTRAR'S SIGNATURE C. Edgar S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

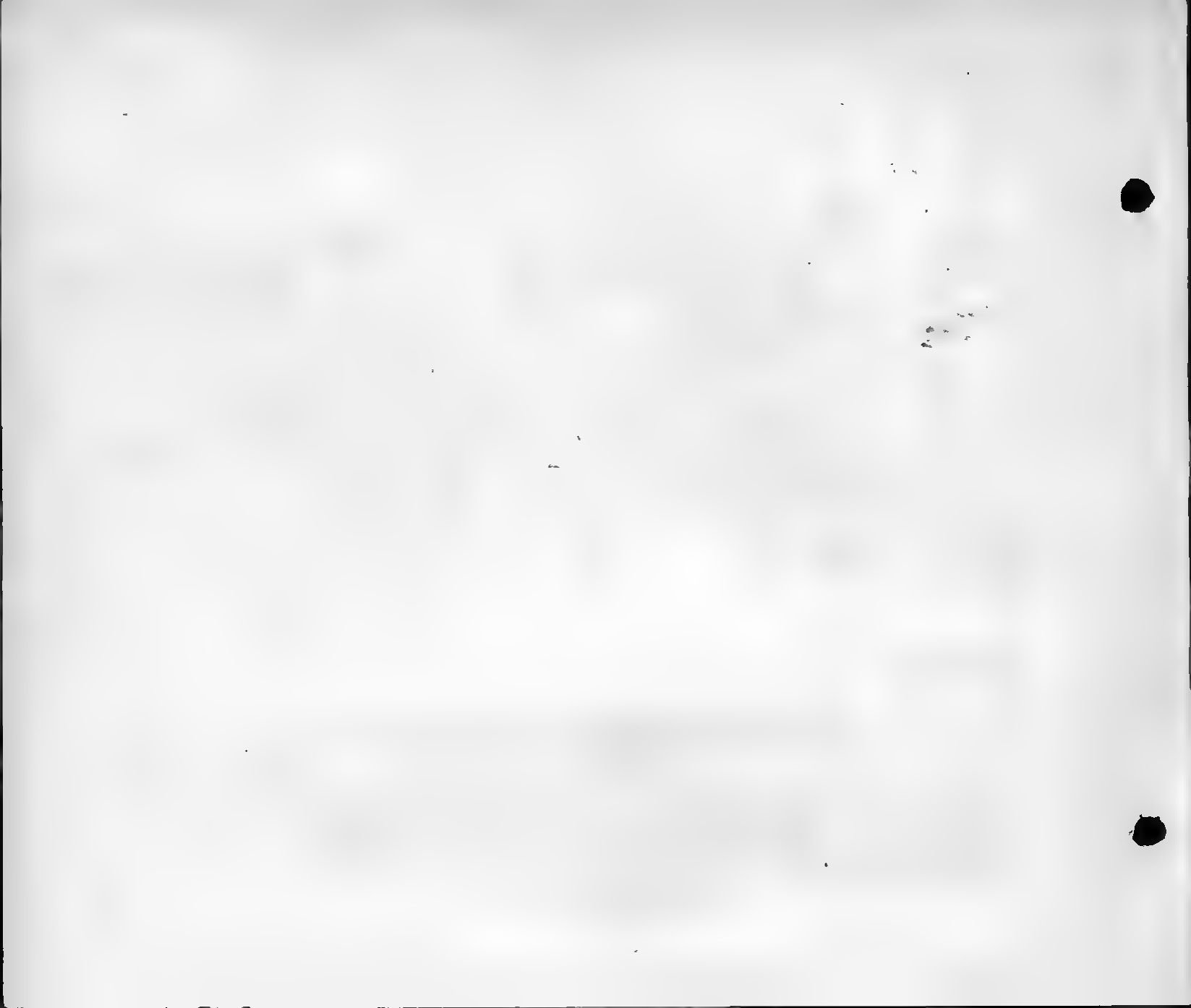
14076

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3800 Elby Ct</u>				d. STREET ADDRESS <u>13800 Elby Ct</u>			
3. NAME OF DECEASED (Type or print) <u>George Joseph Keenan</u>				4. DATE OF DEATH <u>Dec 3 1960</u>			
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>1-30-1919</u>	9. AGE (In years last birthday) <u>41</u> yrs.		10. FUNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanics</u>		11. BIRTHPLACE (State or foreign country) <u>NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo Keenan</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Kliney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mary Keenan (wife)</u> Address <u>Sh 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute Bronchitis - 3 days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-3-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Haverstown N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas B Shanley</u> ADDRESS <u>3831- 94 Ave. NW.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>L. Kneib</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14039

CERTIFICATE OF DEATH

14077

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

MARYLAND

c. LENGTH OF STAY IN 1b

8 hours

2. USUAL RESIDENCE (When deceased lived, if institution, residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium Hospital

e. STREET ADDRESS

17301 Trescott Avenue

f. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Sterling Burgess Kendig

5. SEX

male

6. COLOR OR RACE

white

MARRIED ☐

NEVER MARRIED ☒

8. DATE OF BIRTH

11-20-00

4. DATE OF DEATH

Month

12

Day

20

Year

1960

9. AGE (In years last birthday)

59 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Railway Express Agency

11. BIRTHPLACE (County & State, or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel B. Kendig

14. MOTHER'S MAIDEN NAME

Edna L. Foose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

714-07-8749

17. INFORMANT

Wife

Address

Same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary heart disease

Conditions, if any, which gave rise to immediate cause (b)

(e), stating the underlying cause last.

Left Lateral Lobar Pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20d. INJURY OCCURRED

20e. (City or town)

(County)

(State)

20f. TIME OF INJURY

Hour a.m. p.m.

19

White at work ☐ Not White at work ☐

20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20h. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-20-00, 1960, to 12-20-60, 1960, that (I) (we) last saw the deceased alive on 12-20-60, 1960, and that death occurred at 5:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

Stuart L. Nelson

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS.

☐

22b. DATE SIGNED

12-21-60

22c. PHYSICIAN'S NAME (Type)

STUART L. NELSON

22d. ADDRESS

7600 Carroll Ave., Takoma Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

12/24/60

23c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY

23d. LOCATION (City, town or county)

PRINCE GEO. COUNTY, MARYLAND

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Raymond L. Giska

ADDRESS

SILVER SPRING, MD.

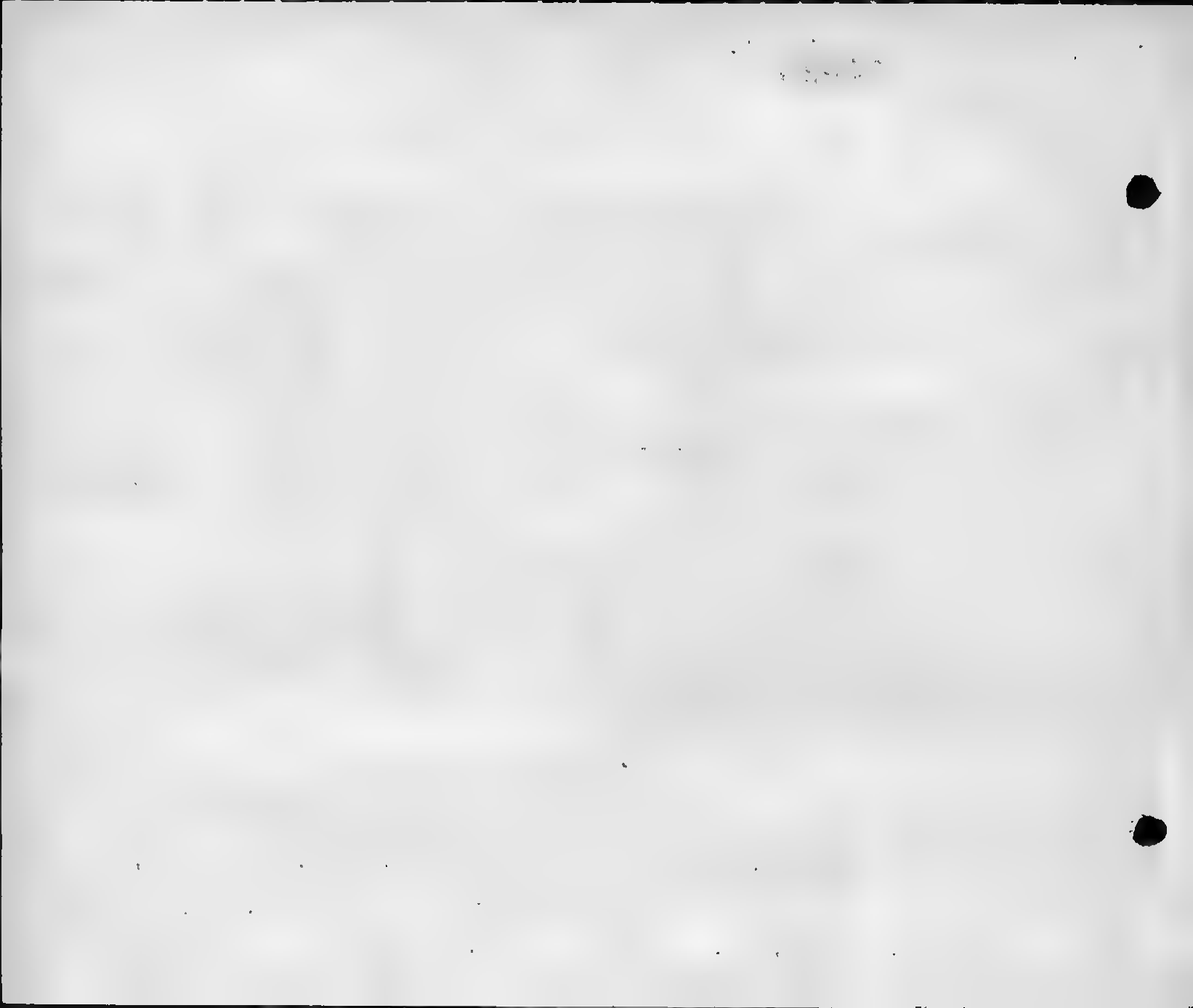
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE DEC 28 '60

Arthur E. F...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabs and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

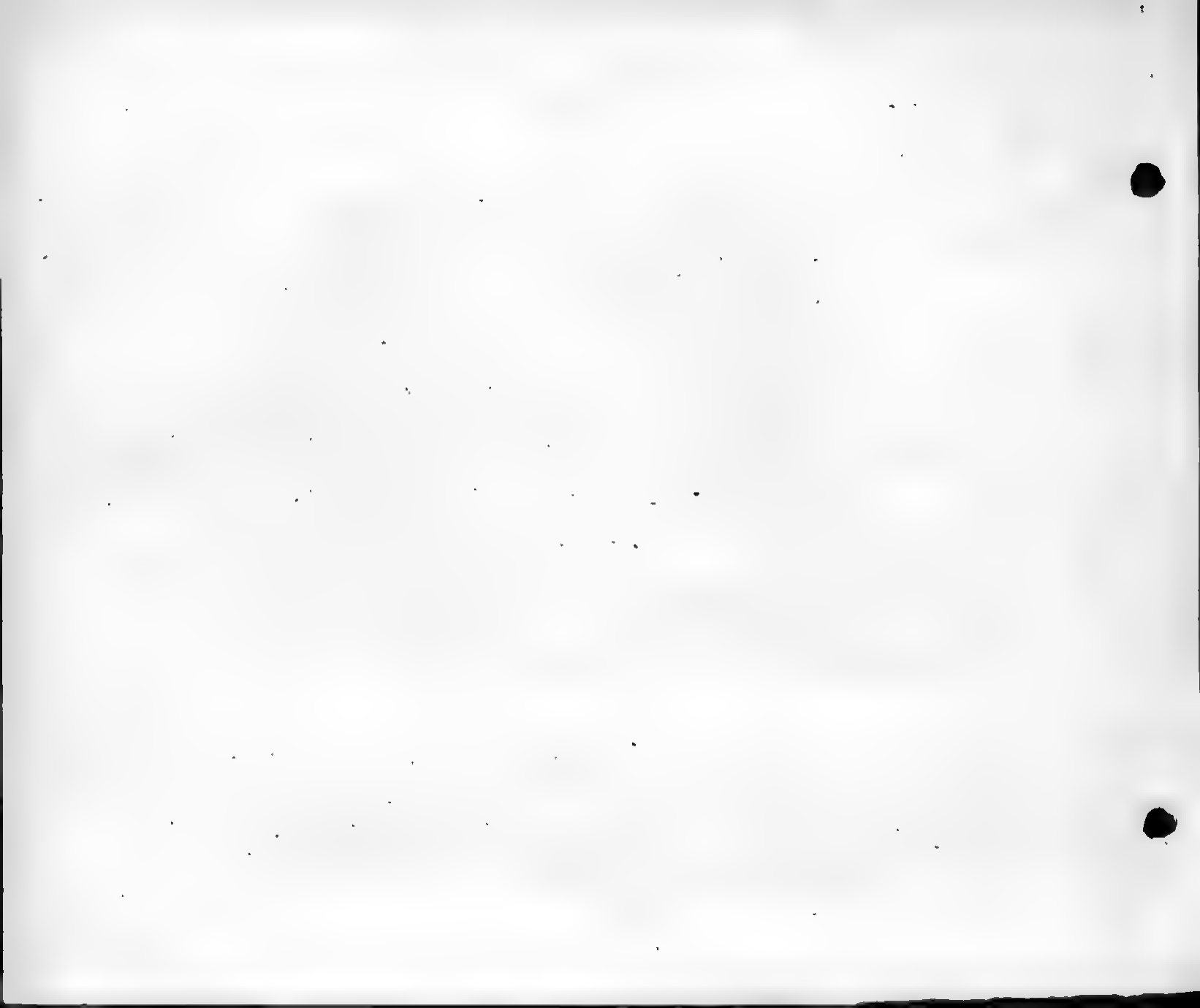
14144

CERTIFICATE OF DEATH

Reg. Dist. No.

14078

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res. denca before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Beallsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cubaan Hospital</u>		d. STREET ADDRESS <u>Rural-Beallsville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ER EST A. KIDWELL</u>		4. DATE OF DEATH Month Day Year <u>Dec. 31, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1907</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Park & Planning Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>UC</u>		12. CITIZEN OF WHAT COUNTRY? <u>UC</u>	
13. FATHER'S NAME <u>Ernest A. Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Katie Hart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO <u>217-18-2080</u>	
17. INFORMANT <u>Dollie Rosalie Kidwell-It...</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 331X DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-25, 1960</u> , to <u>12-31, 1960</u> . That I last saw the deceased alive on <u>12-30, 1960</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>112 Shaw Ave., Silver Spring, Md.</u> DATE SIGNED <u>12-31-60</u> ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. PHYSICIAN'S NAME (Type) <u>John S. Rogers - 112 Shaw Ave., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/1/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Flint Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Oakton Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler - 1331 E Montg. Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14079

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>Seven Locks Road</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>Kinslow</u> Middle <u>Kinslow</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1897</u>	9. AGE (in years last b. day) <u>63</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housemaid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Robert Jones</u>			14. MOTHER'S MAIDEN NAME <u>Emma Vaskeville</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Edward Jones (brother)</u> Address <u>6440 Seven Locks Rd Cabin John Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperkalemic Myocarditis & encephalopathy</u> DUE TO (b) <u>Arterioloneprosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>12 hrs.</u> <u>22</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cabin John, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/5/60</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery.</u>	
22d. LOCATION (City, town, or county) <u>Cabin John, Md.</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Francis</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14080

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Buffington Sanatorium, 1400 Rockville Pike</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>7015 Sycamore Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>George Buffington Kissinger</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-86</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Not Available</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>U.S. Army</u>		16. SOCIAL SECURITY NO. <u>66-11-1</u>	
17. INFORMANT <u>Louis Harrison, 502 Dartmouth Ave. S.E. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>History of previous heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Bellevue, Snyder Co. Pa.</u>	
23. FUNERAL DIRECTOR <u>Arthur C. Peters - 234 Carroll St. W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Peters</u>	



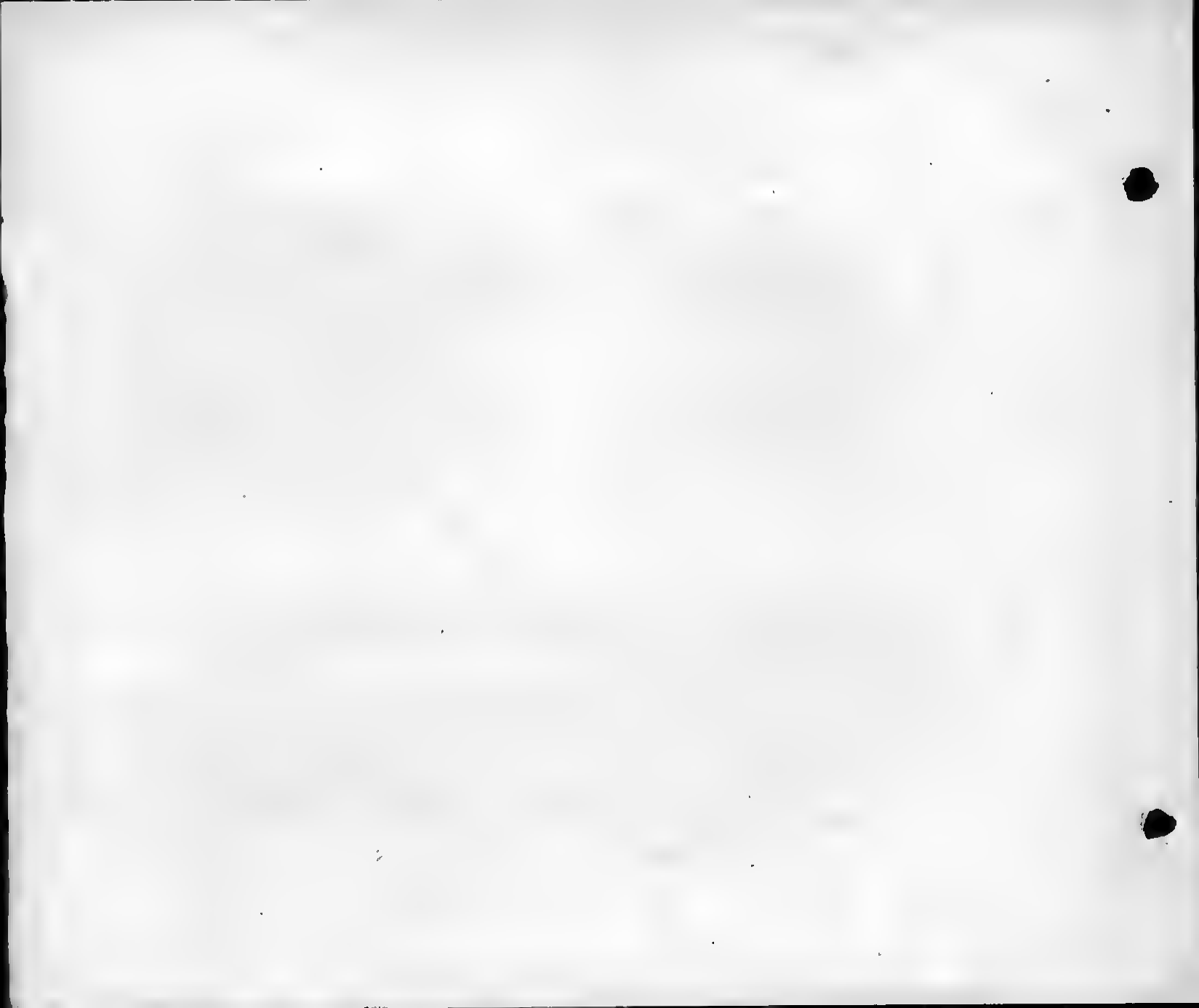
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14146

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

141181

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Hamilton Knox</u> First Middle Last				4. DATE OF DEATH <u>Dec 11 1960</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-97</u>	9. AGE (In years lost birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Maritime Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>statistician</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Knox</u>				14. MOTHER'S MAIDEN NAME <u>Cora Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>1917</u>		17. INFORMANT <u>Wife - Jane Knox - same</u>		Address <u>2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> +20. DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost <u>Coronary atherosclerosis</u> DUE TO (b) <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus - insulin dependent</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>24-30 hours</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> to <u>Dec 11</u> 1960, that (I) <u>was</u> last saw the deceased alive on <u>Dec 11</u> 1960, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Stephen C. Cromwell</u> M.D.				22b. DATE SIGNED <u>12/11/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>	
22d. ADDRESS <u>Rockville, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVA (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12/14/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 15 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>James S. Thomas</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

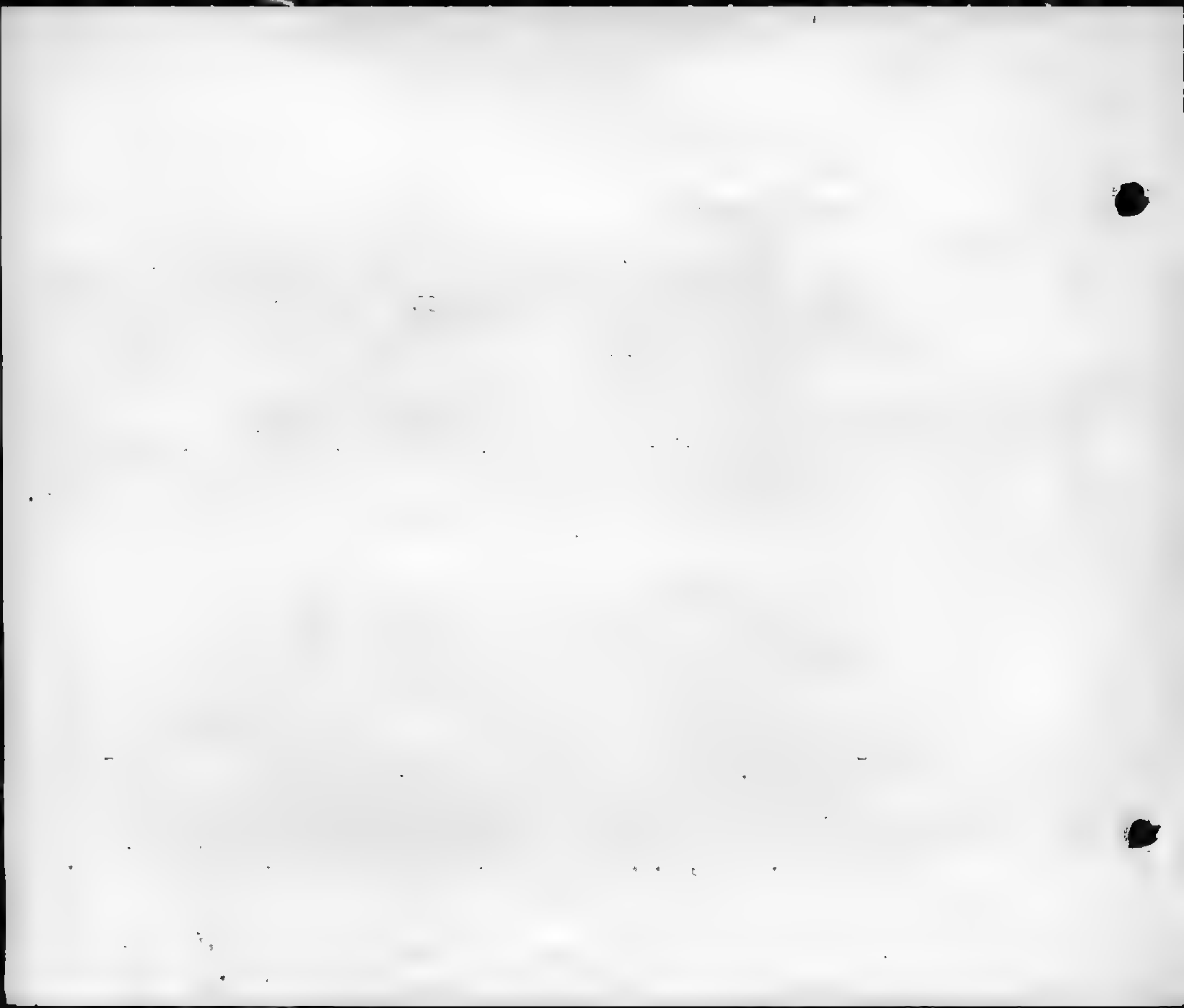
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14147

14082

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 84 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. STREET ADDRESS Route # 3, Box 66	
3 NAME OF DECEASED (Type or print) First Eugene Middle Carl Last Koeln		4. DATE OF DEATH Month December Day 21, Year 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 8, 1931
9 AGE (In years last birthday) 29 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Missouri		12 CIT ZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Koeln		14 MOTHER'S MAIDEN NAME Alma Jundt	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Korean		16 SOCIAL SECURITY NO 400-30-7116	
17 INFORMANT The Medical Record , address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) Thrombocytopenia DUE TO (c) Acute myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 2 months 1 year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (u) (this hospital) attended the deceased from September 28, 1960 to December 21, 1960 , that (u) (we) lost saw the deceased alive on Dec. 21, 1960 , and that death occurred at 9:05 AM from the causes and on the date stated above.			
22a. SIGNATURE Edward E. Morse M.D.		22b. DATE SIGNED 12/21/60	
22c. PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 12/22/60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) St. Louis, Missouri	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a REC'D BY REGISTRAR DEC 27 '60 25b REGISTRAR'S SIGNATURE William E. Morse	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14041

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14083

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>4748 Baltimore Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Esther K. Kuhn</u>		4. DATE OF DEATH Month Day Year <u>December 5 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-97</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry P. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Coates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Admitting Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain tumor</u> DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>12-5</u> , 19 <u>60</u> , and that death occurred at <u>1:18P</u> from the causes and on the date stated above			
22a. SIGNATURE <u>D. R. Purdie</u>		22b. DATE SIGNED <u>12-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. R. Purdie, M. D.</u>		22d. ADDRESS <u>1404 Queensbury Road, Riverdale, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 8, 1960</u>	
23c. NAME OF CEMETERY OR XXXXXX <u>National Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Falls Church Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
25a. REC'D BY REGISTRAR <u>DEC 12 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

14084

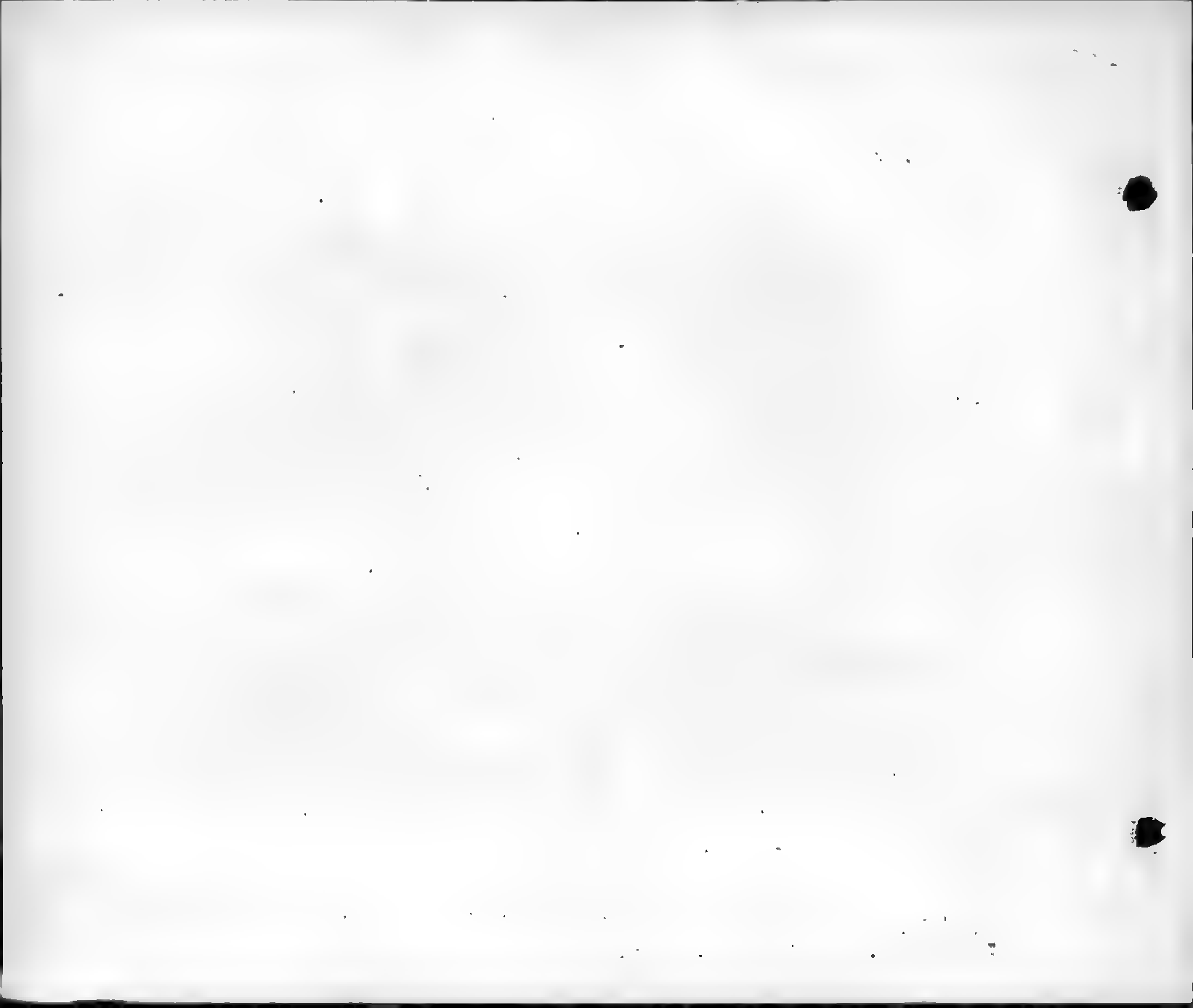
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4415 Rosedale Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bazy</u> First <u>Boy</u> Middle <u>KUSTER</u> Last	4. DATE OF DEATH <u>December</u> Month <u>14</u> Day <u>19</u> Year <u>60</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/60</u>
9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES</u>	14. MOTHER'S MAIDEN NAME <u>CHARLOTTE MAE WRIGHT</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>—</u>	INFORMANT Address <u>Charles Kuster-father-same 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Extradural Hemorrhage</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/14</u> 19 <u>60</u> to <u>12/14</u> 19 <u>60</u> , that I last saw the deceased alive on <u>12/14/60</u> 19 <u>60</u> , and that death occurred at <u>11:20</u> A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Leo E. Dunsen MD</u> M.D.		ADDRESS (Street, city or town, state) <u>8218 Wisc Ave</u> DATE SIGNED <u>12/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Leo E. Dunsen MD</u>		<u>Bethesda Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Bumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hearn</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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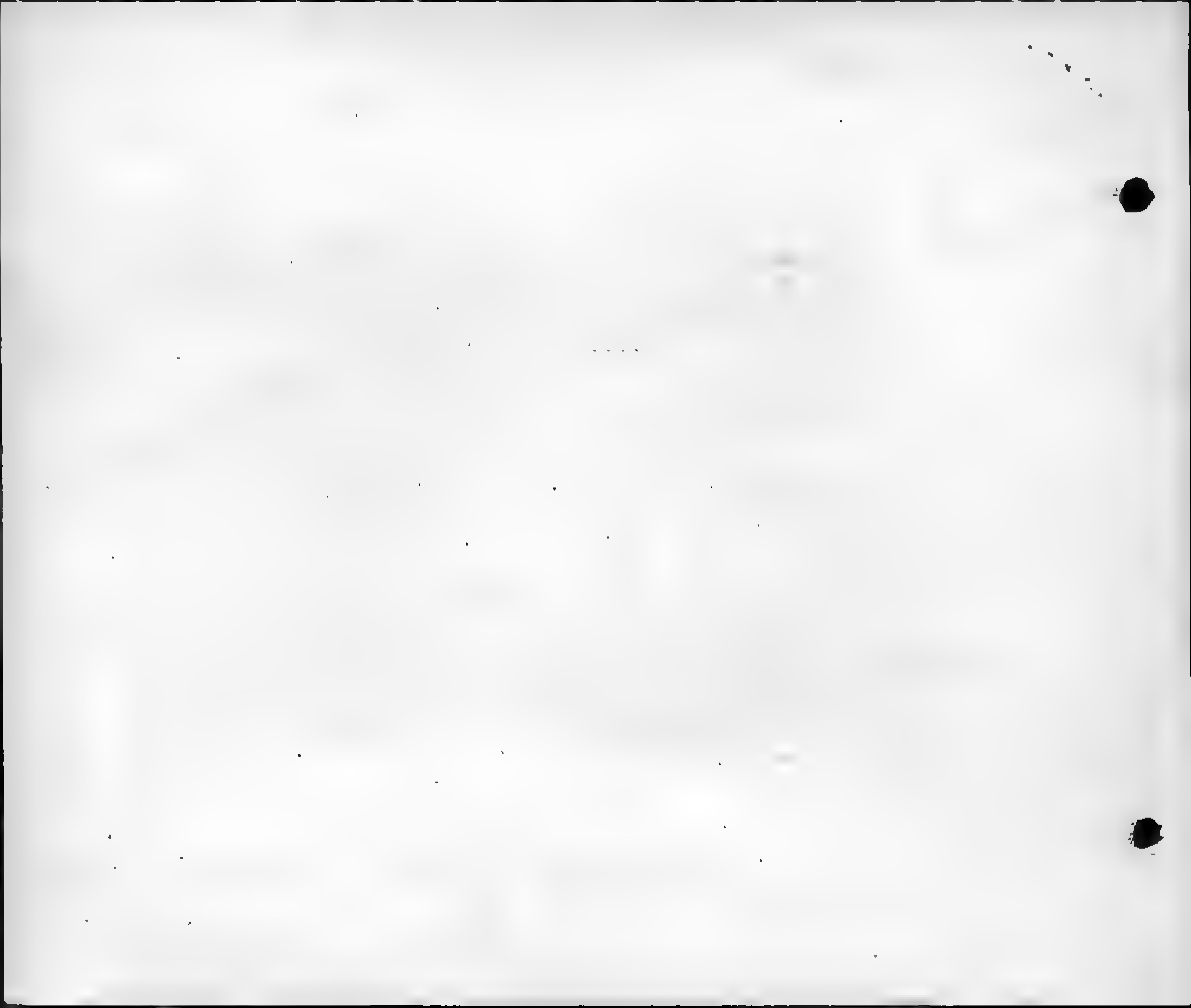
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14149

14085

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601 Huntington Parkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bergliot Middle Larsen Last Larsen				4. DATE OF DEATH Month December Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1883	
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months 5 Days 29		IF UNDER 24 HRS Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? U.S. Natural ized							
13. FATHER'S NAME Theadore Dahl				14. MOTHER'S MAIDEN NAME Bergitte Stromsted			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Von der Fehr-daughter-same 2d			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-2-1958 to 12-18-60 that (I) was lost saw the deceased alive on 12-13-1960 and that death occurred 12-18-60 M, from the causes and on the date stated above							
22a. SIGNATURE C. Roger Kurtz M.D.				22b. ADDRESS 3701 Conn. Avenue NW, Wash. 8, D.C.			
22c. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.				22d. DATE SIGNED 12-18-60			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Bur-transit		12/21/60		Ocean View Cemetery		Staten Island, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 21 '60	
				25b. REGISTRAR'S SIGNATURE Amos L. Hana			



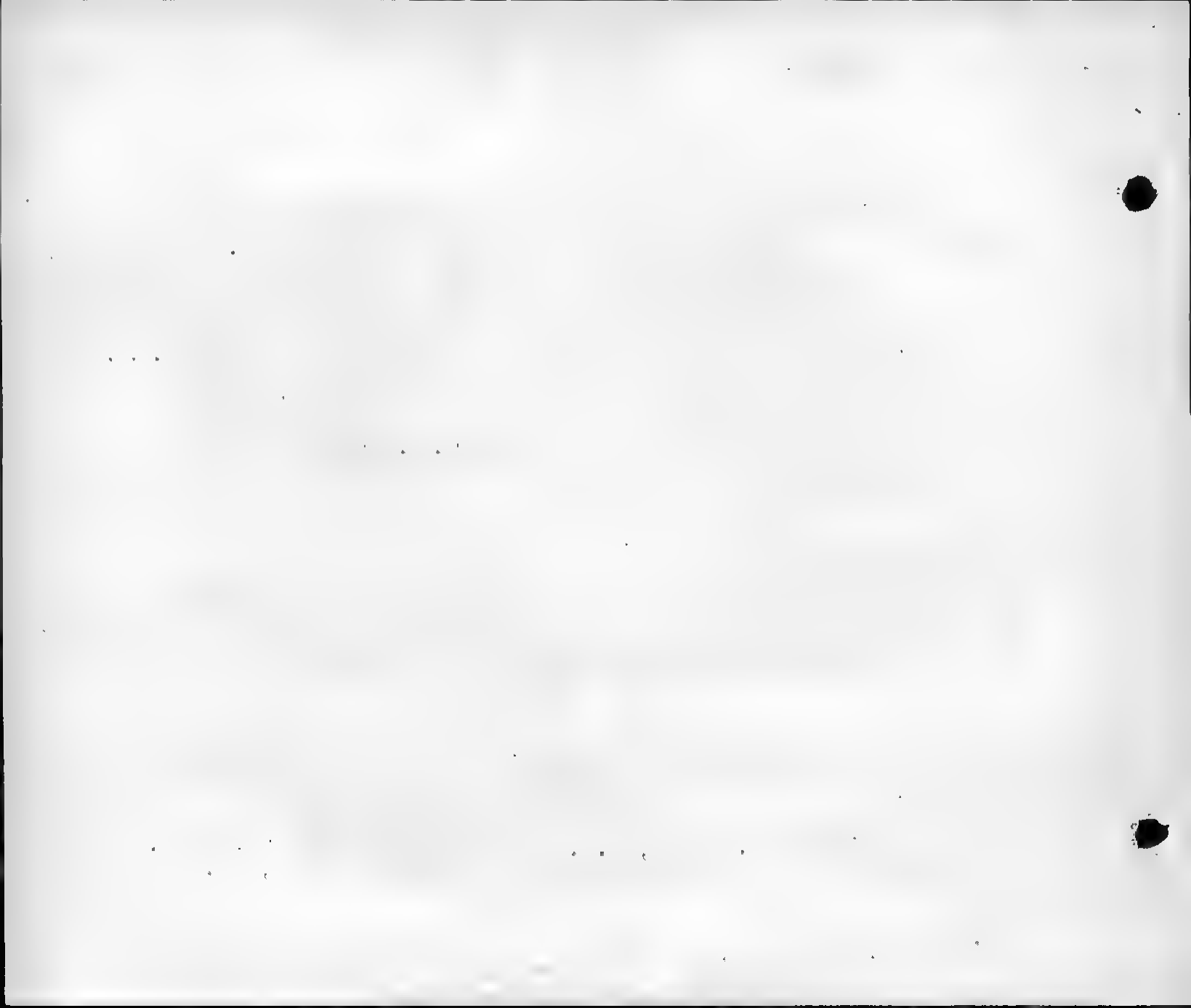
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14150

14086

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 7405 River Road	
3 NAME OF DECEASED (Type or print) First Janie Middle Eudoria Last Lee		4. DATE OF DEATH Month Dec. Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/85
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Lane		14. MOTHER'S MAIDEN NAME Pocohontas Saffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Niece (Mrs. C. Pratt)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Multiple Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to Dec. 18, 1960 , that (I) (we) last saw the deceased alive on Dec. 27, 1960 , and that death occurred at 1:23 AM , from the causes and on the date stated above.			
22a. SIGNATURE W. T. Joyce		22b. DATE SIGNED 12/28/60	
22c. PHYSICIAN'S NAME (Type) William T. Joyce, M.D.		22d. ADDRESS 8106 Maple Ridge Rd. Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/31/60	
23c. NAME OF CEMETERY OR CREMATORY Clifton Cemetery		23d. LOCATION (City, town, or county) (State) Clifton, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR DEC 29 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Edith L. Kinner	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14042
14087

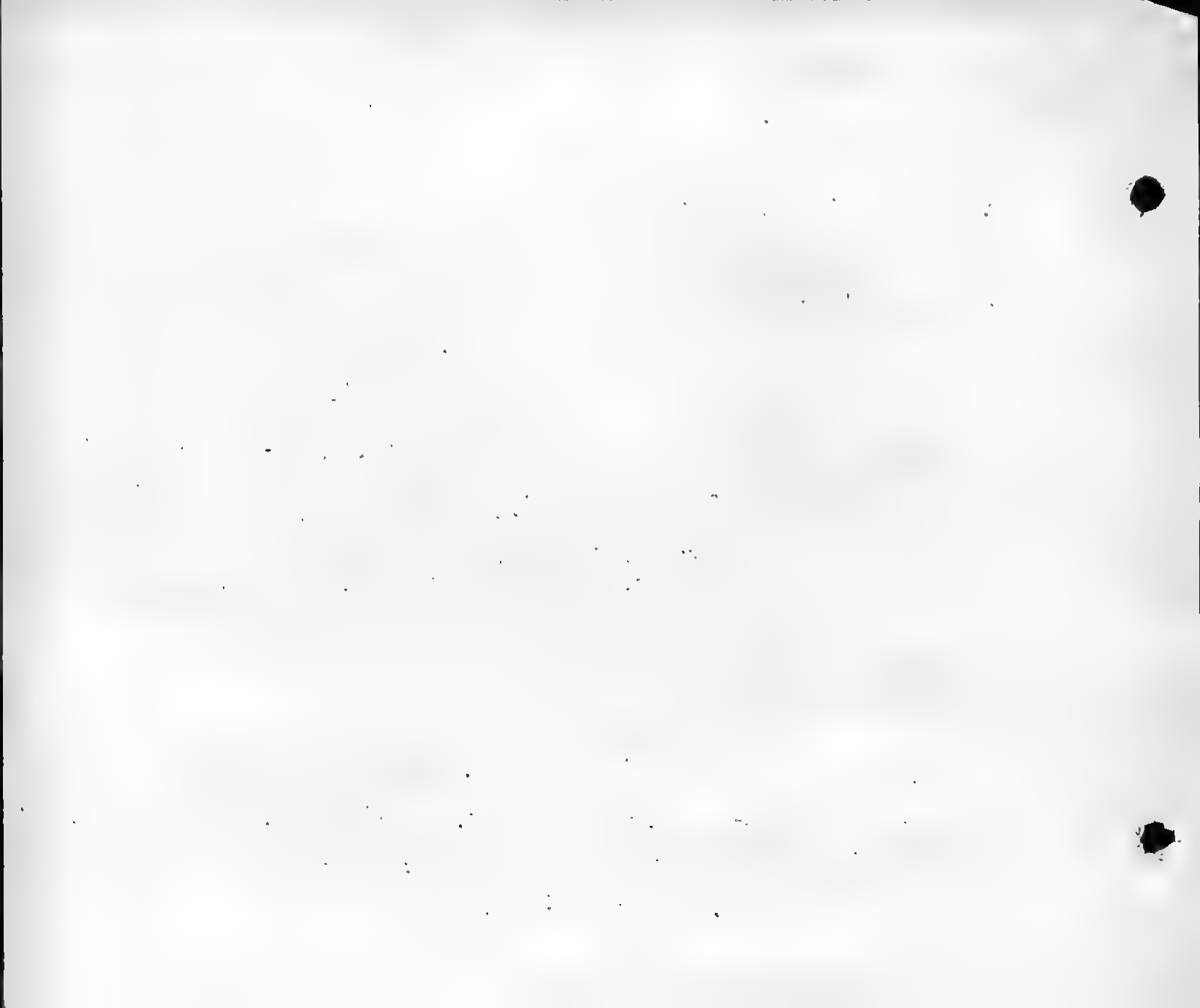
Item 8 FilmG278 1-6-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

14087

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Wash. D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM				d. STREET ADDRESS 2028 Nichols Ave. S.E.			
3. NAME OF DECEASED (Type or print) First Frances Middle Levy Last Levy				4. DATE OF DEATH Month Dec. Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (in years last birthday) 75 yrs		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min 75		IF UNDER 24 HRS Months 75 Days 75 Hours 75 Min 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Levy				14. MOTHER'S MAIDEN NAME Minnie Levy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. Jerome Levy 2028-Nichols Av. S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Cerebral thrombosis 2 night Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hemiplegia DUE TO arteriosclerotic and (c) Hypertensive Cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months 7 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 60				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 2 , 19 60 , to Dec 28 , 19 60 , that I last saw the deceased alive on Dec 28 , 19 60 , and that death occurred at 10:00 A.M., from the causes and on the date stated above				ADDRESS (Street, city or town, state) DATE SIGNED 9500 Colson Rd Silver Spring Md 12/28/60			
ACTUAL SIGNATURE H. B. Orleans				M.D. 9500 Colson Rd Silver Spring Md			
PHYSICIAN'S NAME (Type) H. B. ORLEANS							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Ohey Shalom-Talmud Torah Cem.		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & Sons				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 3 1961	
				24b. REGISTRAR'S SIGNATURE Henry S. Evans			



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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

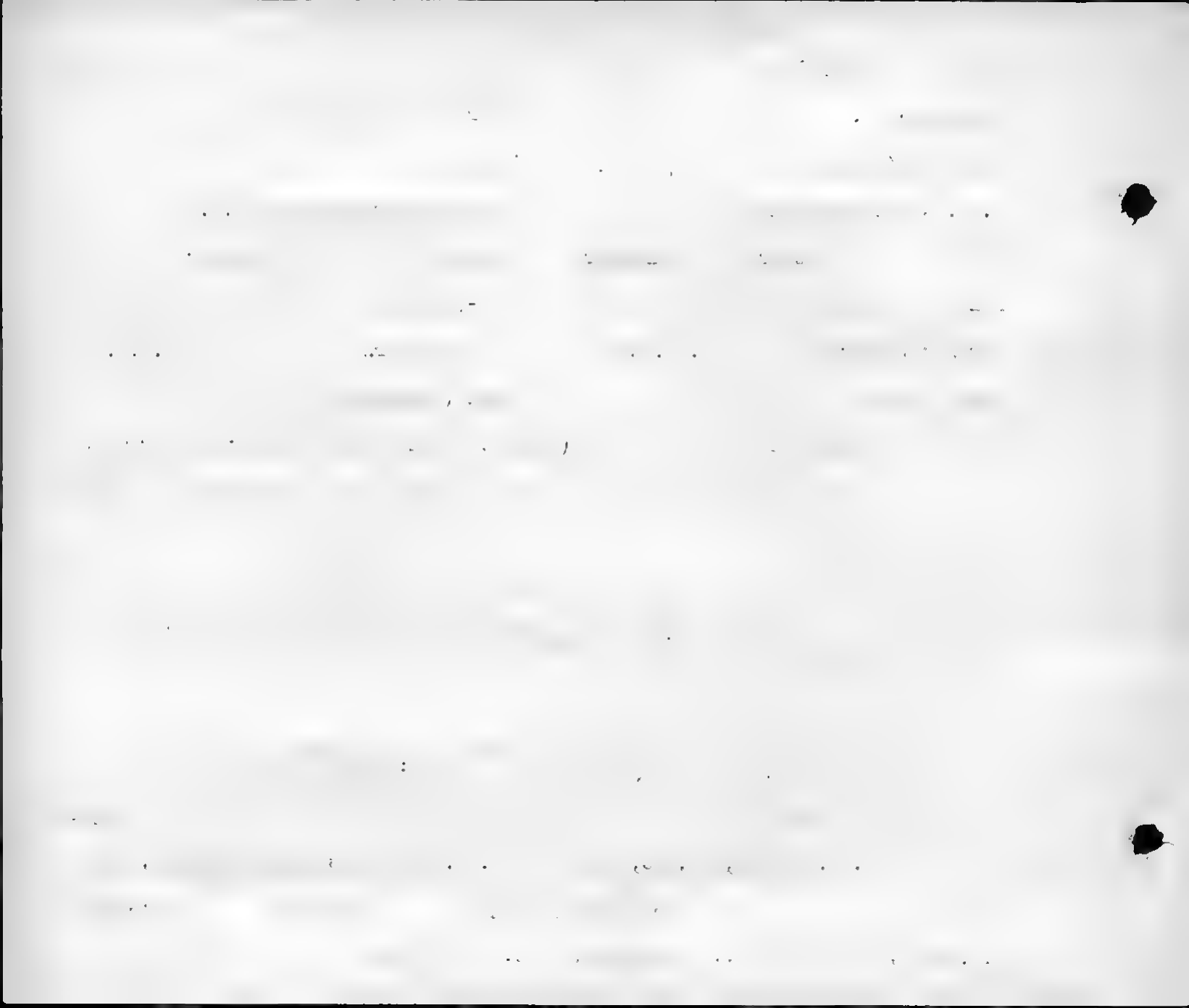
TO HOSPITAL: This certificate may be retained by the hospital or attending physician.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14151

14088

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7½ hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 6223 Piney Branch Road, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles MacHenry LINDSAY				4. DATE OF DEATH Month Day Year December 18 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-90	
9. AGE (In years last birthday) 70 yrs		10. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David LINDSAY				14. MOTHER'S MAIDEN NAME Emma (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, give war or dates of service 1911 to 1945				16. SOCIAL SECURITY NO. (W) Mrs. Ethel R. Lindsay, same as #2 above			
17. INFORMANT (W) Mrs. Ethel R. Lindsay, same as #2 above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ulcer, Stomach NEC & Hemorrhage DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Arteriosclerotic Heart & Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Dec. 18 19 60 to Dec. 18 19 60 that (X) (we) last saw the deceased alive on Dec. 18 19 60 , and that death occurred at 11:14 PM , from the causes and on the date stated above.							
22a. SIGNATURE W. D. HOOVER				22b. DATE SIGNED 12-19-60			
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE S.H. HINES				25a. REC'D BY REGISTRAR DEC 23 '60			
25b. REGISTRAR'S SIGNATURE Clara S. Hines							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

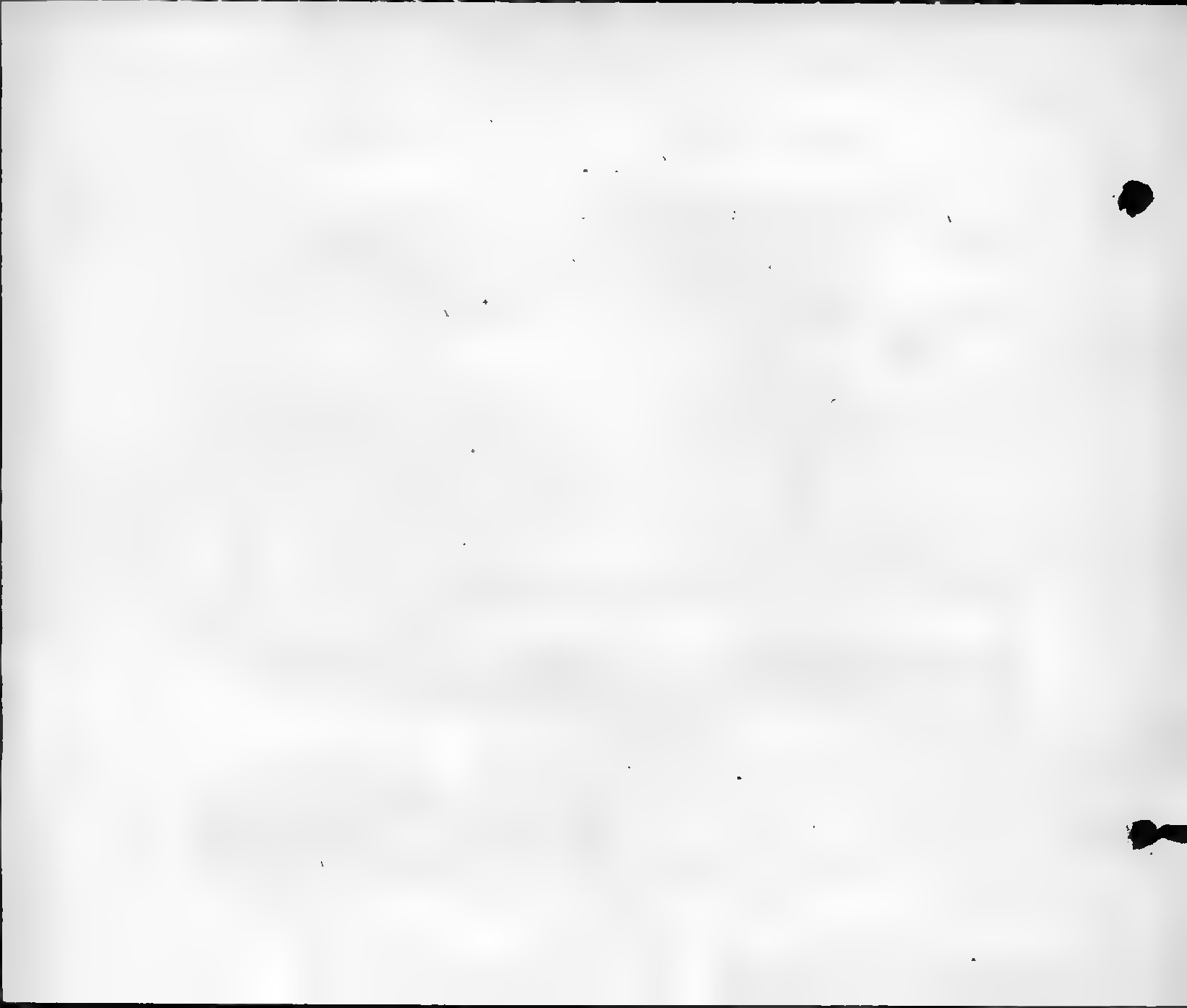
VR A15 (4)
15M 9/59

14152

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14089

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>/19hrs. 25min</u> <u>Dayton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>				d. STREET ADDRESS <u>13X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Louise</u> Last <u>Linthicum</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 18</u> <u>1883</u>	
9. AGE (in years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Susie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas H. Linthicum, Dayton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cardiac failure</u> DUE TO (c) <u>Bronchial pneumonia</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>36 hours</u> <u>36 hours</u>							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>50</u> to <u>December 18</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec. 17</u> 19 <u>60</u> , and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Charles S. Whitaker</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles Whitaker, M.D.</u>				22d. ADDRESS <u>Clarksville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-20-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>		23d. LOCATION (City, town, or county) (State) <u>Glenelg, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Whitaker</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14153

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14090

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1hr. 45 min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Annandale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 166 Hummer Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last DELBERT WARREN LYNCH				4. DATE OF DEATH Month Day Year December 11 1960			
5 SEX Male		6 COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12-11-60	
9 AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days 1 45		IF UNDER 24 HRS Hours Min 1 45		10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Don Leon LYNCH				14. MOTHER'S MAIDEN NAME Violet June THOMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16 SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Don L. Lynch, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) prematurity 776 X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 11, 1960 to Dec. 11, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 11, 1960 and that death occurred at 6:05 AM from the causes and on the date stated above.							
22a. SIGNATURE Fred W. Grello M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-11-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-13-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE DEC 13 '60		25b. REGISTRAR'S SIGNATURE Chas. L. Frank	

Ans

at the death certificate be executed within 24 hours of death. Page 4

by the attending physician and completely filled in by the funeral director.
The above form is not to be used for the purpose of a death certificate.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14154

14091

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Mexico b. COUNTY Mexico City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 55 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mexico City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Uruguayan Embassy			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Dulcia Middle Pereira Last MAC EACHEM				4. DATE OF DEATH Month December Day 11 Year 1960			
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-29-08		9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Uruguay		12. CITIZEN OF WHAT COUNTRY? Uruguay ✓
13. FATHER'S NAME Jose Maria Pereira y Rocha				14. MOTHER'S MAIDEN NAME Dulcia CORTINAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (H) R.E. MacEachen, Uruguayan Embassy, London,		Address England	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lymphoblastic Lymphosarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 17, 1960 to Dec. 11, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 11, 1960 , and that death occurred at 9:50PM from the causes and on the date stated above.							
22a. SIGNATURE F. H. O'Connell				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-12-60	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 12-13-60		23c. NAME OF CEMETERY OR CREMATORY R. A. Pumphrey Funeral Home, Bethesda, Md.		23d. LOCATION (City, town or county) (State) Mexico City Mexico	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. RECORDING REGISTRAR'S SIGNATURE DEC 13 1960		25b. REGISTRAR'S SIGNATURE DEC 13 1960	

TO HOSPITAL ATTENDING PHYSICIAN: This page 3 should be detached for use as the cause of death certificate, and in any event within 72 hours after death.

-8-

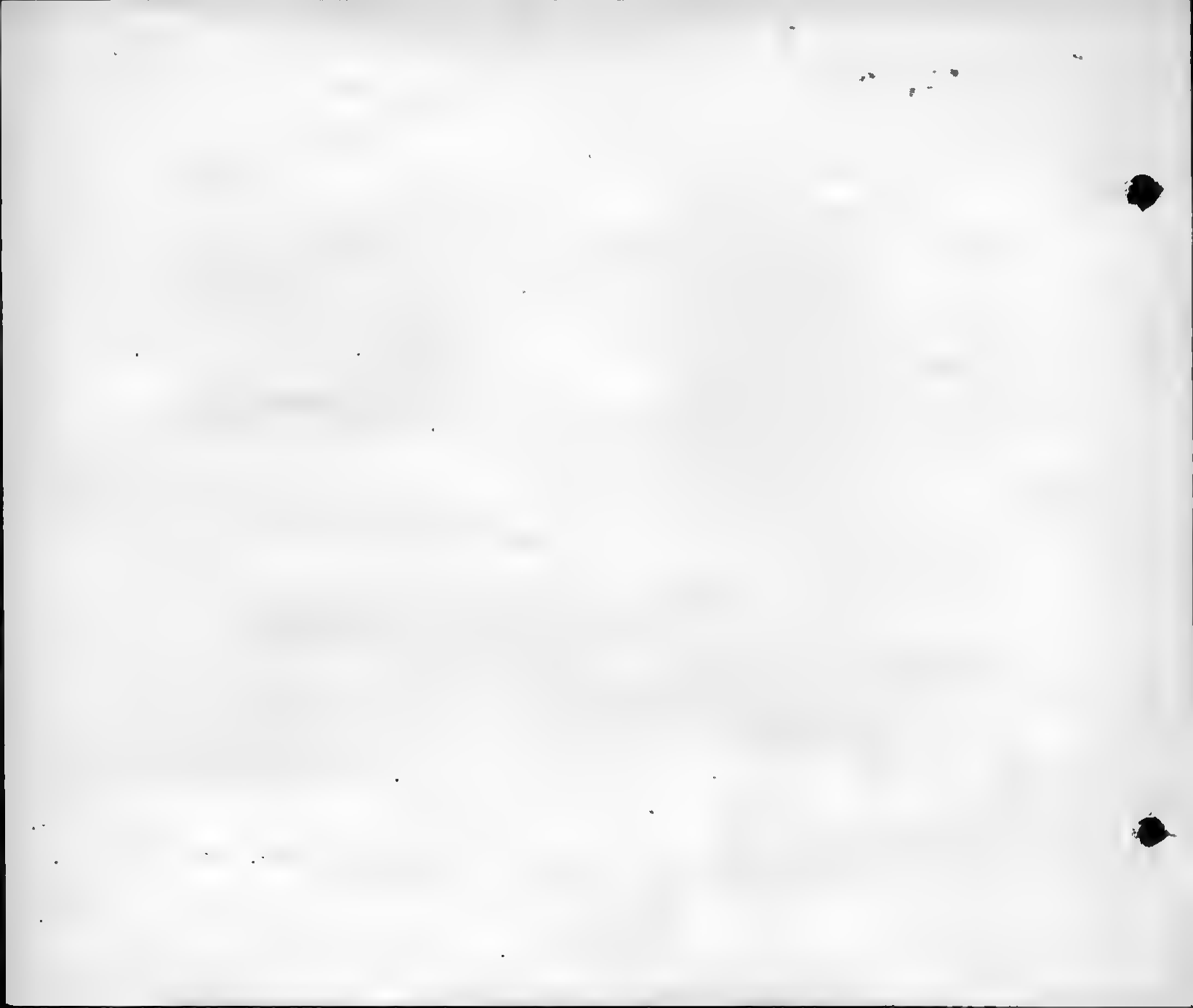
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14092

14155

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 14 Hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 1109 EDMONSTON DR.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN S. MAC SPORRAN				4. DATE OF DEATH Month Day Year 12/30/60 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/ 18	
9. AGE (In years lost birthday) 42 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Managerment		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN A. MAC SPORRAN				14. MOTHER'S MAIDEN NAME ELIZABETH MACFARLANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO ARMY WW II 045-03-6465		17. INFORMANT Mrs. Susanna C. MacSporran WIFE (SAME AS ABOVE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Confluent bronchopneumonia, bilateral DUE TO Pneumococcus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Massive Fatty Metamorphosis liver							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 to Dec. 30, 19 60 that (I) (we) last saw the deceased alive on Dec. 30, 60 and that death occurred at 12:30 AM, from the causes and on the date stated above							
22a. SIGNATURE Charles Savarese, MD				22b. ADDRESS 4890 Battery Lane, Bethesda, Md.		22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE	
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation 12-31-60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. H...	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

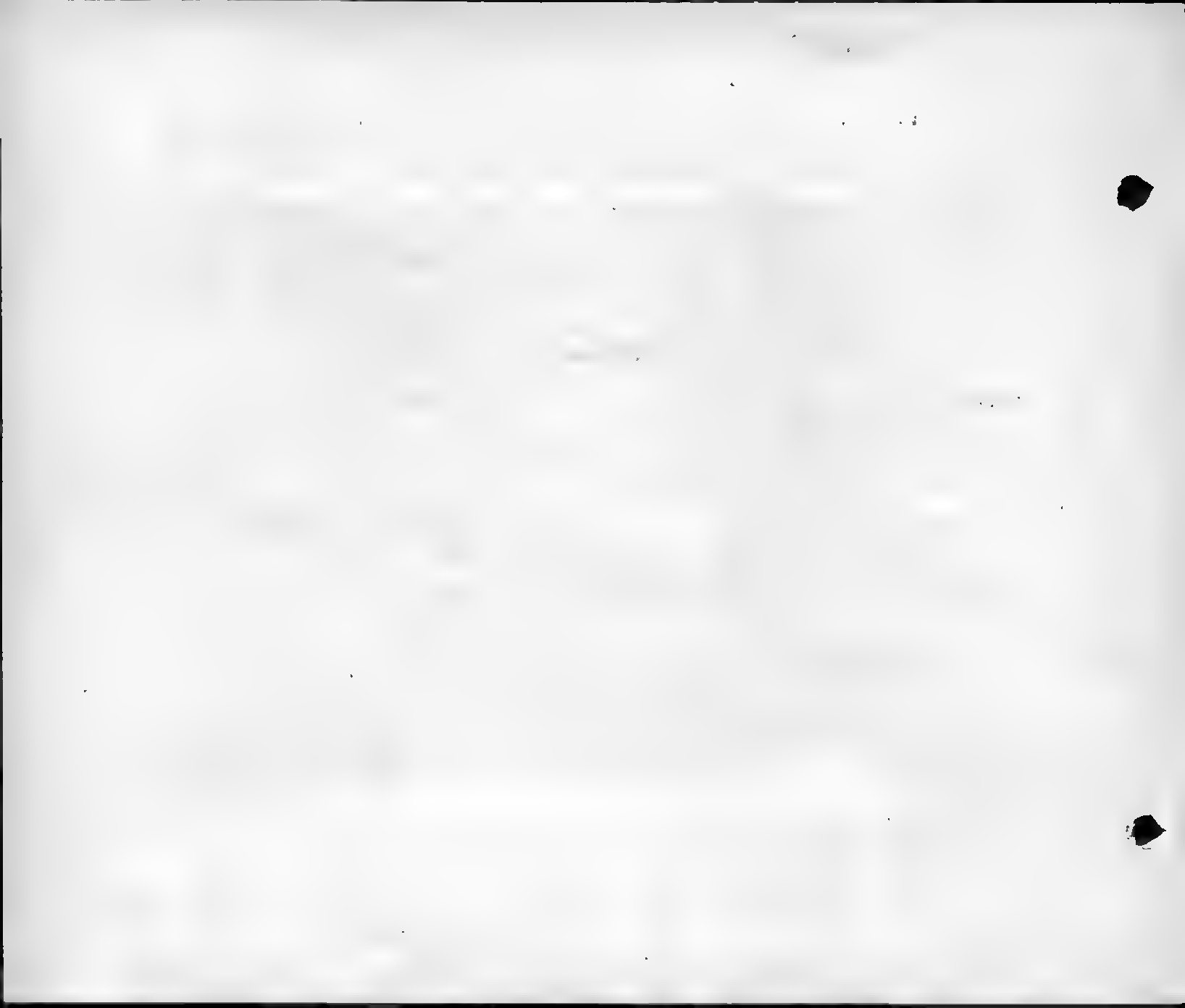
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

14043

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14093

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS 2420 - 16th Street, N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Nell none Manda		4. DATE OF DEATH Month Day Year December 24 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-5-84
9. AGE (In years lost birthday) 76 yrs		10. UNDER 1 YEAR Months Days 4 19	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant business		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James Martin Hysong		14. MOTHER'S MAIDEN NAME Anna Gross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mary O. Hysong		Address 1300 N. St., N.W. Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Emotive heart failure, cont. shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ac myocardial infarction post and pre-existing cont. infarction (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 12/18/1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Washington, D.C.	
21. I certify that (I) (this hospital) attended the deceased from 12/18/1960 to 12/24/1960 that (I) (we) last saw the deceased alive on 12/24/1960 and that death occurred at 11:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE H. Stolohom		22b. DATE SIGNED 12/24/1960	
22c. PHYSICIAN'S NAME (Type) Dr. H. Stolohom		22d. ADDRESS 7600 Carroll Ave. Lhman Ph, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/27/1960	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Blacksburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hysong's Funeral Home		25a. REGD. BY REGISTRAR DEC 27 '60	
ADDRESS 1300 N. St., N.W.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



14156

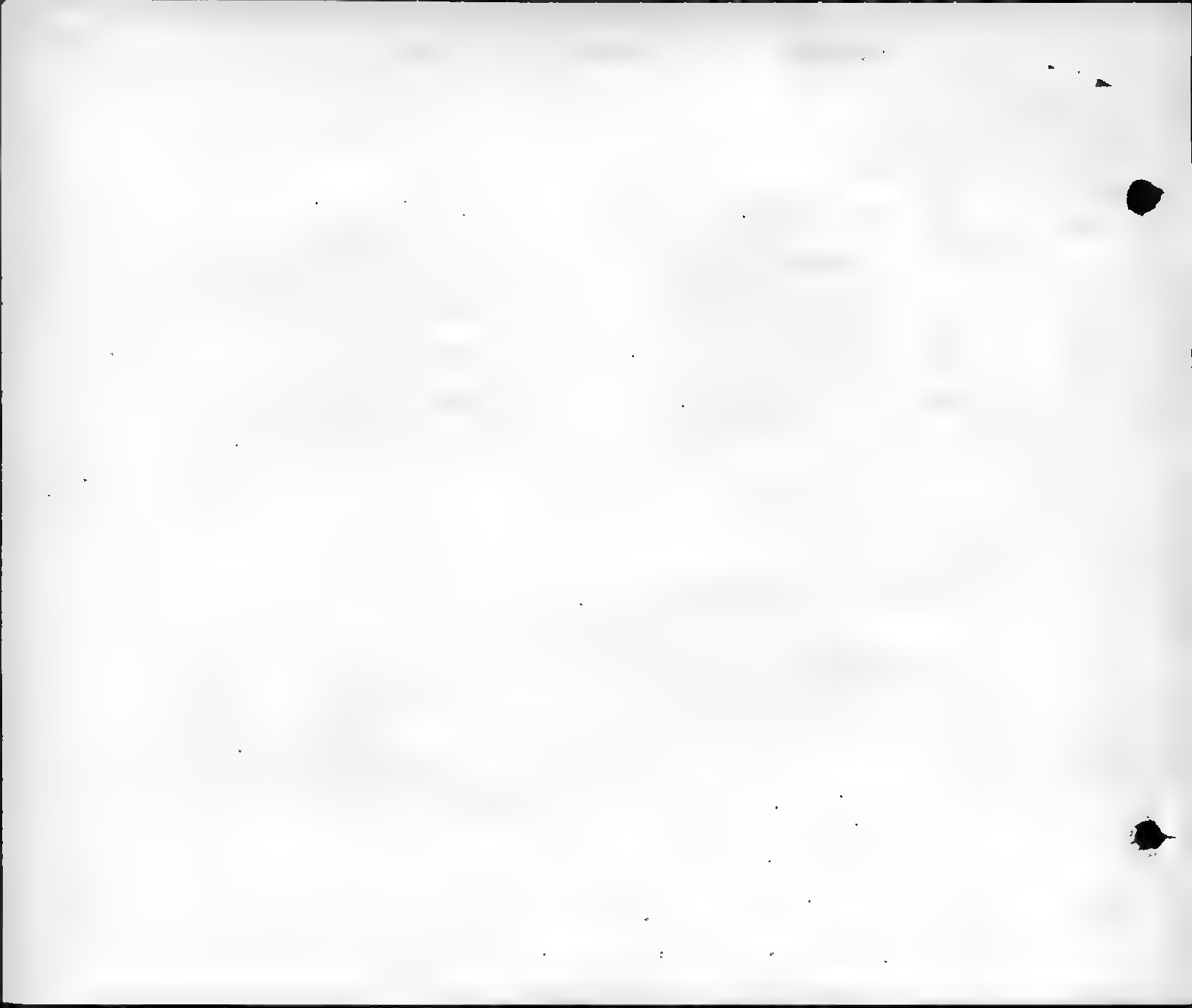
CERTIFICATE OF DEATH

14094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 9218 ALDERSHOT DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HARLIN Last MARKLEY		4. DATE OF DEATH Month 12/10/60 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/06
9. AGE (In years last birthday) 54 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Research	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Simon MARKLEY		14. MOTHER'S MAIDEN NAME Myrtle Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Yes Unknown	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.01 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WIFE(SAME AS ABOVE) Margaret Markley			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. I certify that I attended the deceased from July 1, 1960 to 12/10, 1960 , that I last saw the deceased alive on 12/10, 1960 , and that death occurred at 12:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville Md.	
ACTUAL SIGNATURE Stephen N. Jones M.D.		DATE SIGNED 12/10/60	
PHYSICIAN'S NAME (Type) STEPHEN N. JONES		809 Viers Mill Rd. Rockville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/13/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince George Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 12/15/60 DATE 12/15/60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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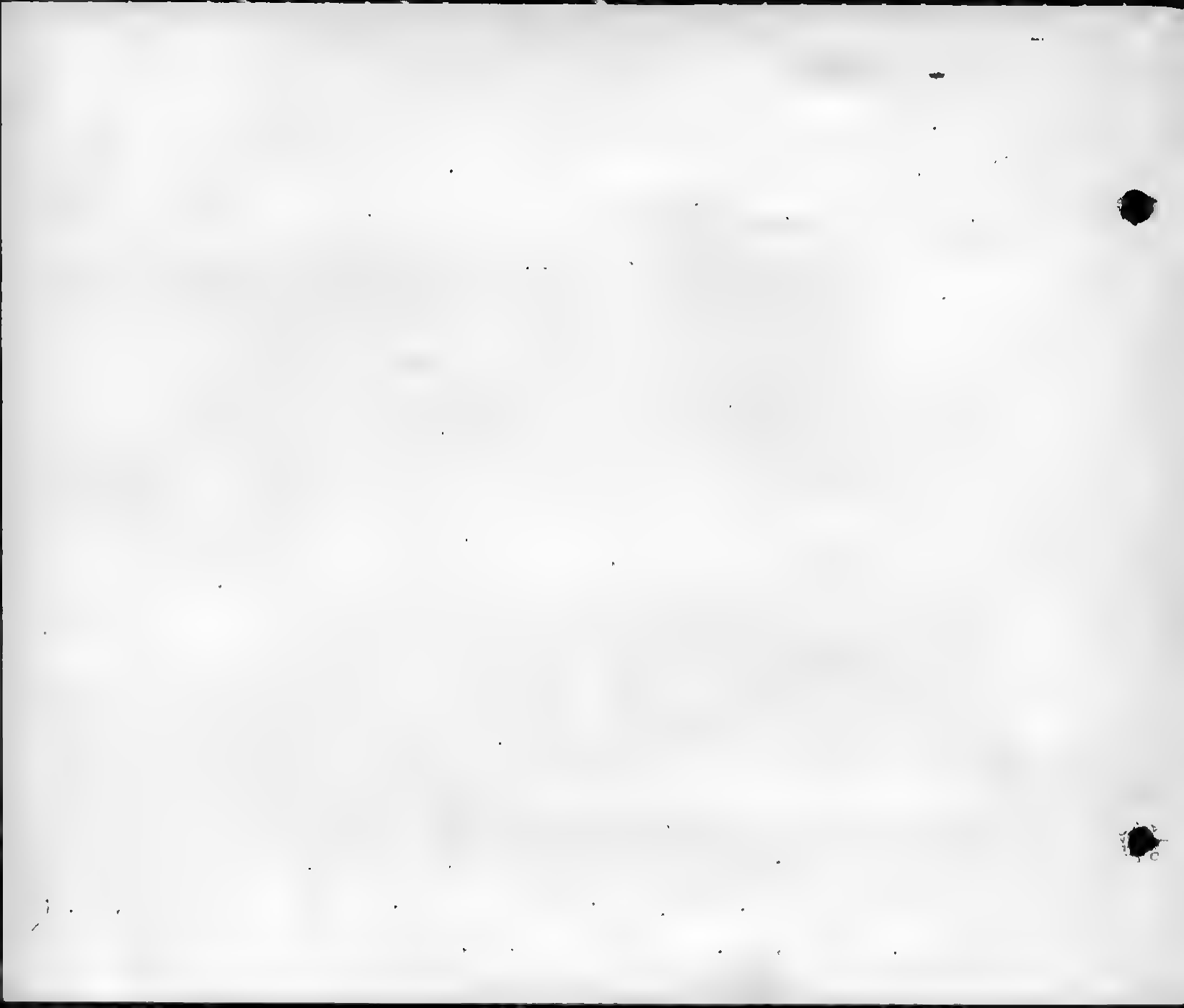
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14044

14095

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u> d. STREET ADDRESS <u>RED #2, 12921 Columbia Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Clark Marlow</u> First Middle Last				4. DATE OF DEATH <u>December 12 1960</u> Month Day Year					
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-81</u>		9. AGE (In years last birthday) <u>79</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner of farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Pinkney Marlow</u>				14. MOTHER'S MAIDEN NAME <u>Emma Clark</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Hospital Records</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible shock</u> 5/1.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal obstruction</u> DUE TO <u>Strangulated Rt. Inguinal hernia</u> (c) <u>Gangrene terminal ileum & perforation</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days?</u> <u>hca.?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes & senility</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12-1960</u> to <u>12-12-1960</u> , that (I) (we) last saw the deceased alive on <u>12-12-1960</u> , and that death occurred at <u>7:57 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Paul V. Starr</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 13-1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>				22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>					
23a. BURIAL, CREMAT OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PIMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14157

CERTIFICATE OF DEATH

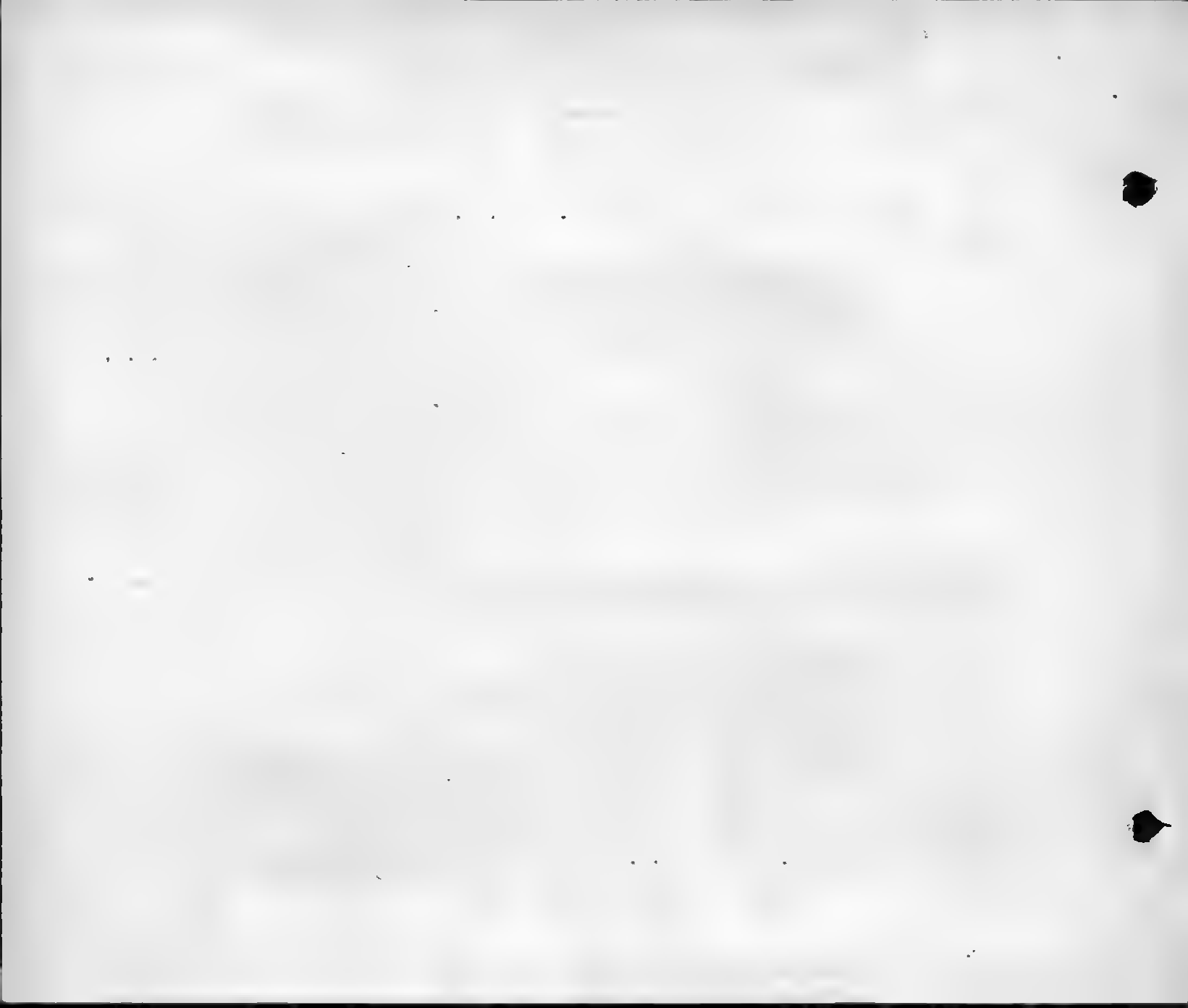
Reg. Dist. No.

14093

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS R. D. #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Steven Gene Marshall				4. DATE OF DEATH Month Day Year December 25, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1960		9. AGE (In years last birthday) Yrs Months Days 26 9 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Marshall				14. MOTHER'S MAIDEN NAME Mary N. Avant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atelectasis and pneumonia DUE TO (c) Malignant sarcoma							INTERVAL BETWEEN ONSET AND DEATH days weeks months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 20, 1960 to December 25, 1960 , that I last saw the deceased alive on December 25, 1960 , and that death occurred at 6:35 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome B. Black				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/26/60			
PHYSICIAN'S NAME (Type) Jerome B. Black M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/60		22c. NAME OF CEMETERY OR CREMATORY Salmon Union Cemetery		22d. LOCATION (City, town, or county) (State) Dover Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Funeral Home		24a. REC'D BY REGISTRAR DATE DEC 29 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VR A15 (4)
15M 9/59

1

14158

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14097

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R.F.D. #1</u>				c. LENGTH OF STAY IN 1b <u>1 yr 3 mos</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annons Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Mo Pherson</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/1879</u>			
9. AGE (In years last birthday) <u>81</u> yrs		f. UNDER 1 YEAR Months <u> </u> Days <u> </u>		g. UNDER 24 HRS Hours <u> </u> Min <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Samuel Bacon</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Putman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT (Address) <u>Mrs Josephine Prather</u> (Daughter) (Same as above)									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> DUE TO (b) <u>Senility.</u> DUE TO (c) <u>chronic myocarditis</u> CONDITIONS, if any which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Rockville, Md</u>				20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>12-23, 1960</u> to <u>12-23, 1960</u> that (I) (we) last saw the deceased alive on <u>12-23, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above									
22a. SIGNATURE <u>Luciano I. Lead</u>				22b. DATE SIGNED <u>12/27/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Lead</u>				22d. ADDRESS <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cemetery</u>		23d. LOCATION (City, town, or county) <u>Rockville, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Prader</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>3 '61</u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

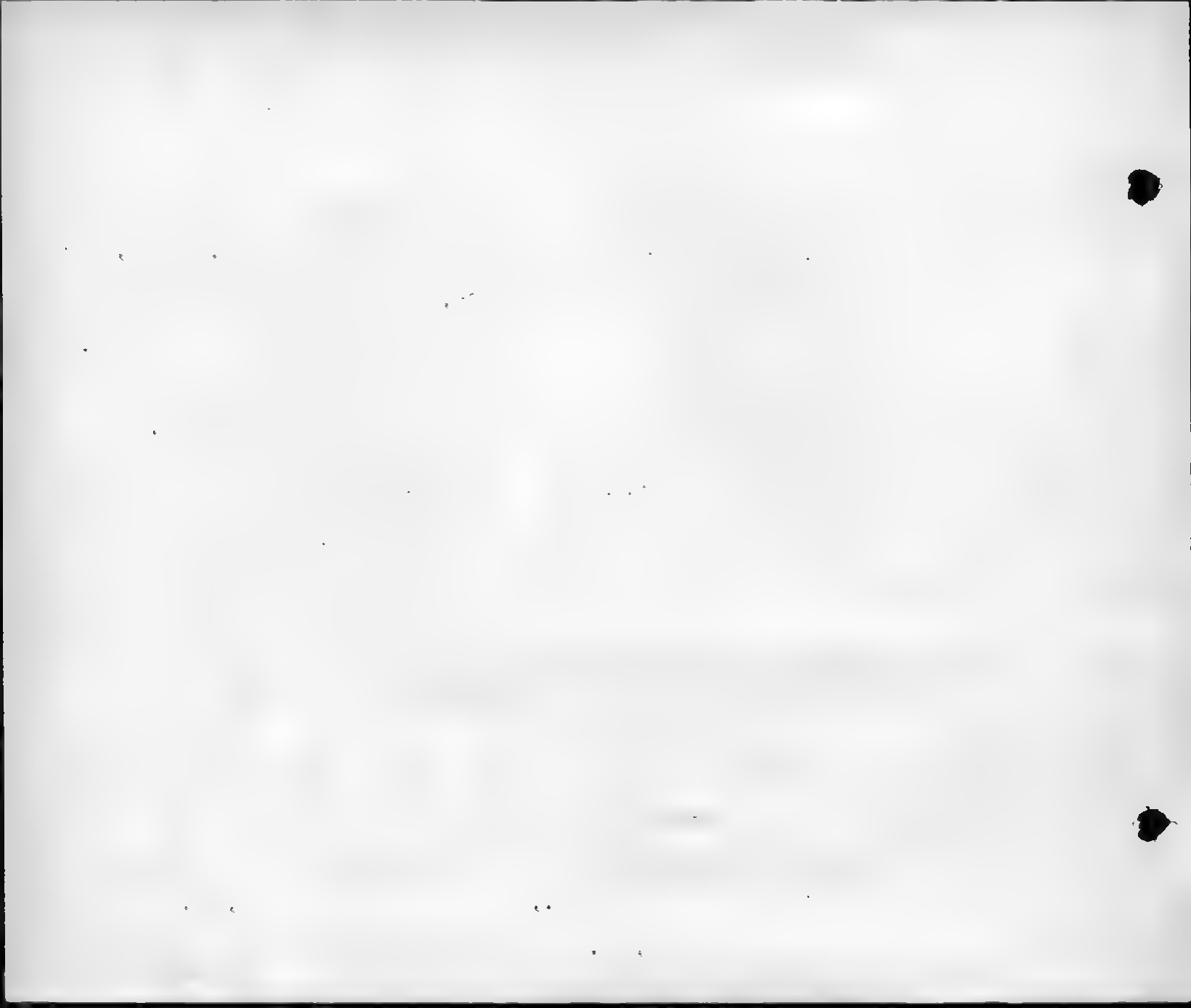
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14159

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14098

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>			
c. LENGTH OF STAY IN lb <u>life</u>				d. STREET ADDRESS <u></u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u></u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANKLIN</u> Last <u>MASON</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1891</u>		9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John F. Mason</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mildred Stewart</u> Address <u>Germantown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>428-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1960</u> to <u>Dec 18, 1960</u> , that (I) (we) lost saw the deceased alive on <u>Dec 17, 1960</u> , and that death occurred <u>4:00 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Vernon E. Marten</u> M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 20-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vernon E. Marten</u>				22d. ADDRESS <u>Germantown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>burial</u>	<u>12/22/60</u>	<u>Brownstown.</u>		<u>Germantown, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shroder</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

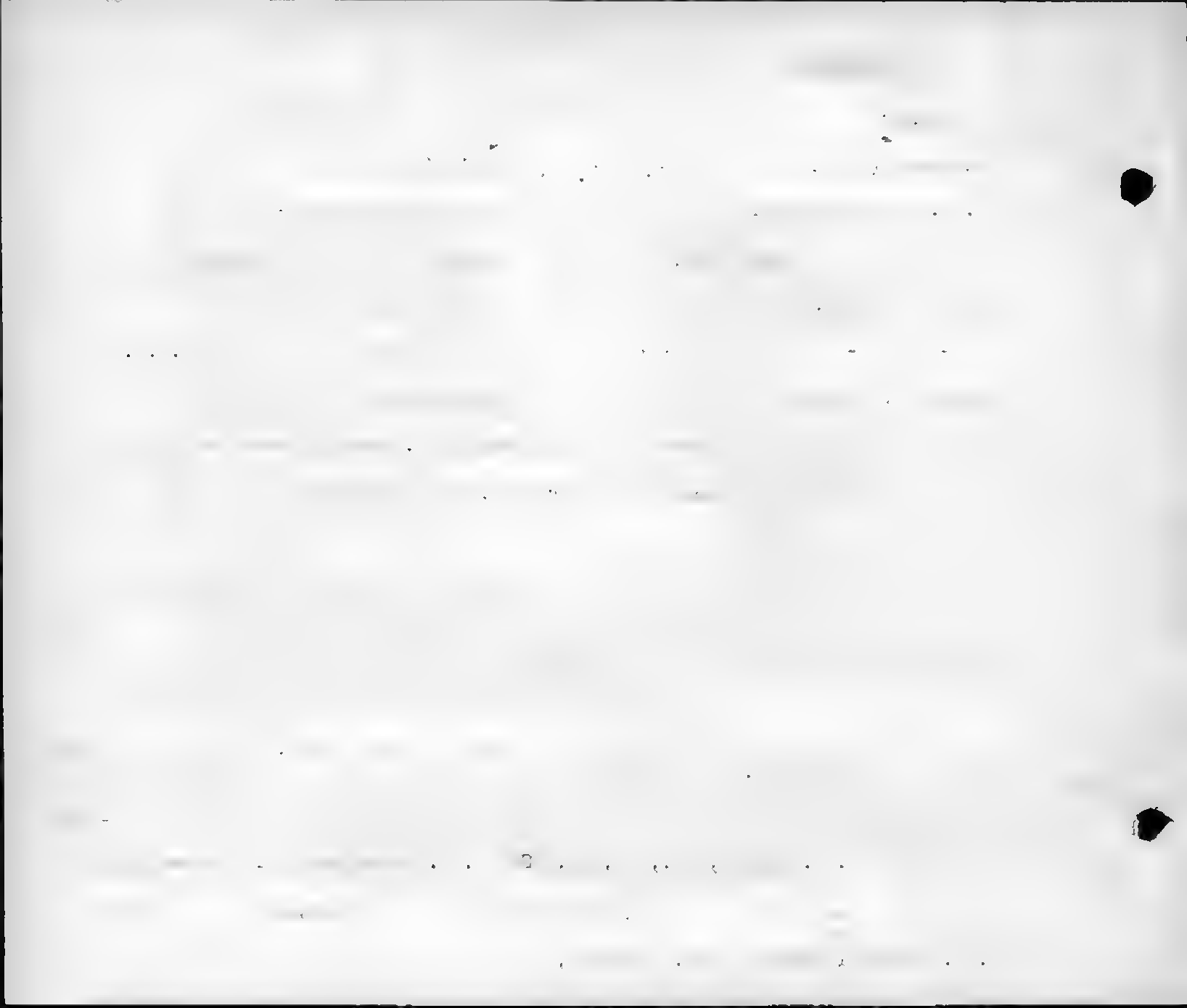
1

14160

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14093

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 15 min.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington 19 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 d. STREET ADDRESS 304 Anacostia Road - Apt. 302 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl, MATHIAS		4. DATE OF DEATH Month Day Year December 5 19 60	
5. SEX Female	6. COLOR OR RACE Mongolian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-60
9. AGE (In years lost birthday) yrs 15		10. FINDER 1 YEAR Months Days Hours Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrett V. MATHIAS		14. MOTHER'S MAIDEN NAME Sumiko HATANO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Garrett V. Mathias, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (appr. 18 weeks gestation) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the deceased attended the deceased from Dec. 5 19 60 to Dec. 5 19 60 , that (I) the deceased last saw the deceased alive on Dec. 5 19 60 , and that death occurred at 5A AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>A. O. Anctil, Jr.</i>		22b. DATE SIGNED 12-5-60	
22c. PHYSICIAN'S NAME (Type) A. O. ANCTIL, JR., LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-60	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town, or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. A. Pumphrey</i>		25a. REC'D BY REGISTRAR DEC 7 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Knecht</i>		25c. DATE DEC 7 '60	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

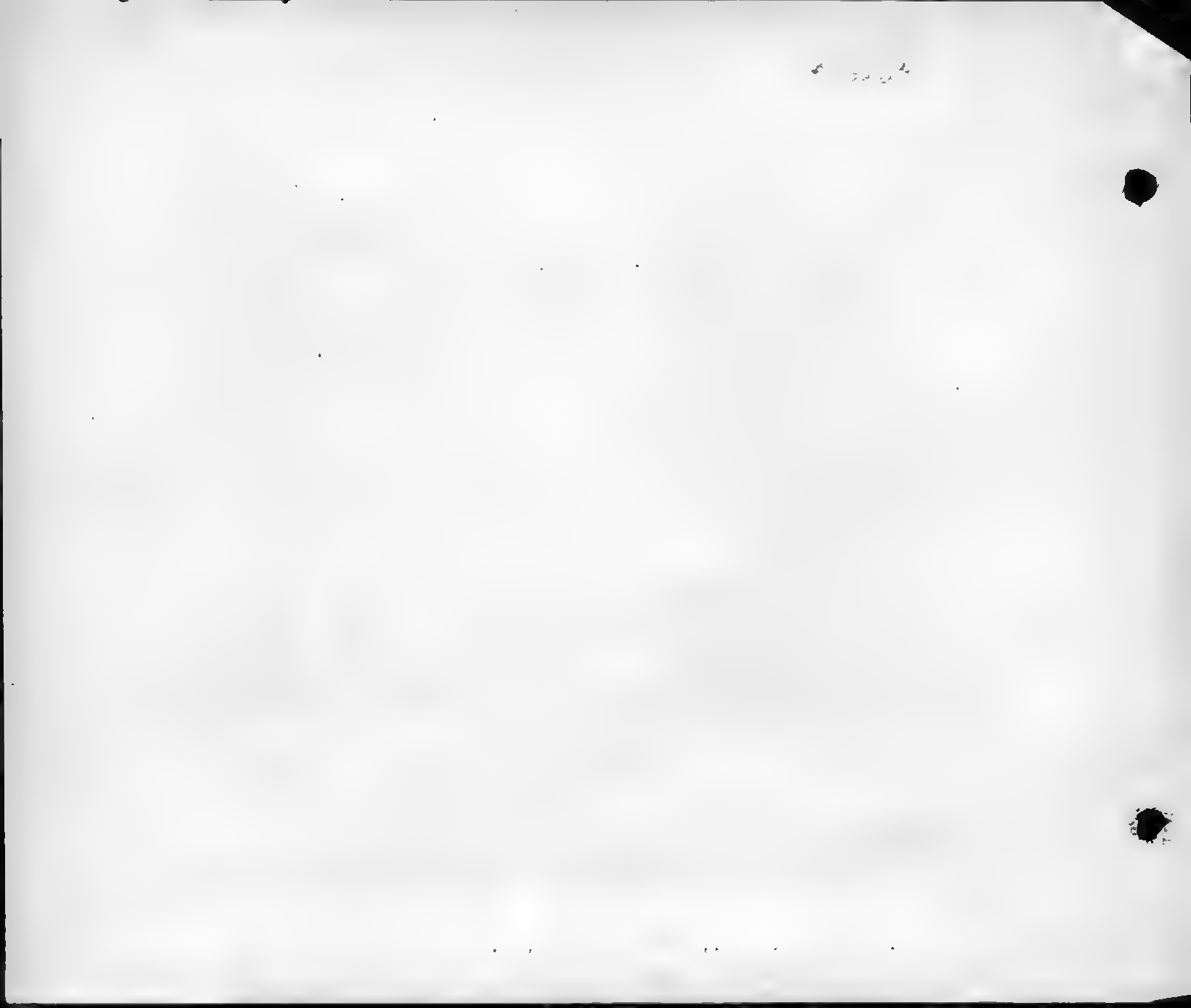
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14045

CERTIFICATE OF DEATH

141.0

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>California</u> b. COUNTY <u>SAN MATEO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Brea Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monte Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>D. Clark Matthew</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-11</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V. + - - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Jackson, Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>A</u>	
13. FATHER'S NAME <u>D. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>36610 1231</u>	
17. INFORMANT <u>Sch. R. Martin</u>		Address <u>14 - - - - -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Acute Myocardial Infarction</u> (b) <u>4 hrs.</u> DUE TO <u>2 hrs.</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3:30 PM Dec 15, 1960</u> to <u>3:45 PM Dec 15, 1960</u> . That (I) (we) last saw the deceased alive on <u>Dec 15, 1960</u> and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>12/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		22d. ADDRESS <u>% Washington Sanitarium & Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 19, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Uppeland; Waltham; Mich.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>	
25b. REGISTRAR'S SIGNATURE <u>John L. K. K.</u>		DATE <u>DEC 19 '60</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

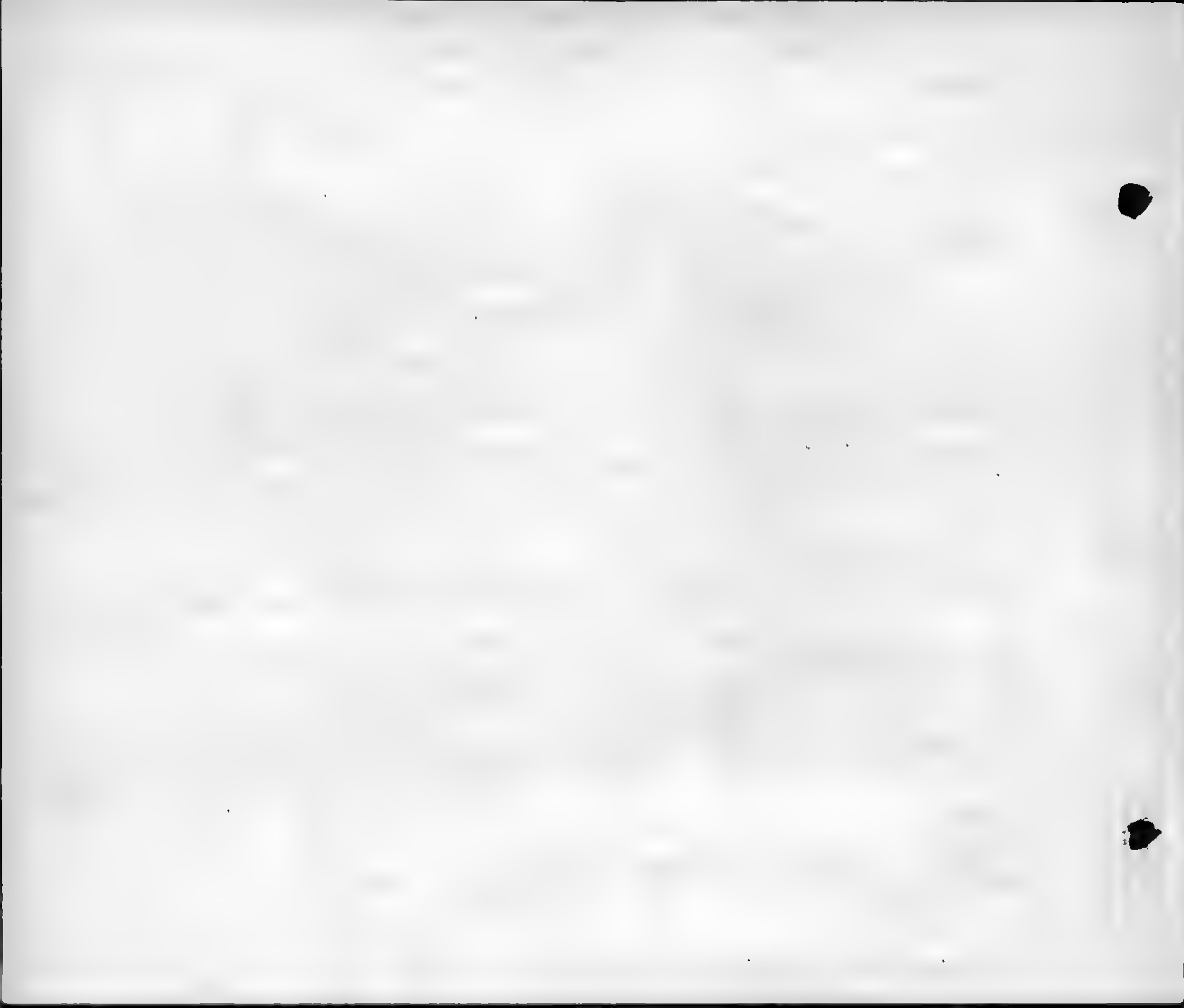
14046

CERTIFICATE OF DEATH

Reg. Dist. No.

1-101

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>8 yrs</u>		12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>McCurdy</u> Last		4. DATE OF DEATH <u>Dec 23</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 13 1893</u> yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlotte NC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Abernathy</u>		14. MOTHER'S MAIDEN NAME <u>Ann Abernathy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>100-4</u> INFORMANT <u>Wm. Lee</u> Address <u>1100 17th St N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pneumonia</u> DUE TO <u>7-5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7-5</u> DUE TO <u>7-5</u> (c) <u>7-5</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> p. m. Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> to <u>Dec 23, 1960</u> , that I last saw the deceased alive on <u>Dec 23, 1960</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md</u>	
DATE SIGNED <u>12/23/60</u>			
22a. BURIAL, CREMATION, OR REMOVAL <u>REMOVAL</u>	22b. DATE THEREOF <u>12-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee's Sons Co. 300-4th Street N.E.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 28 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hume</u>



14012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

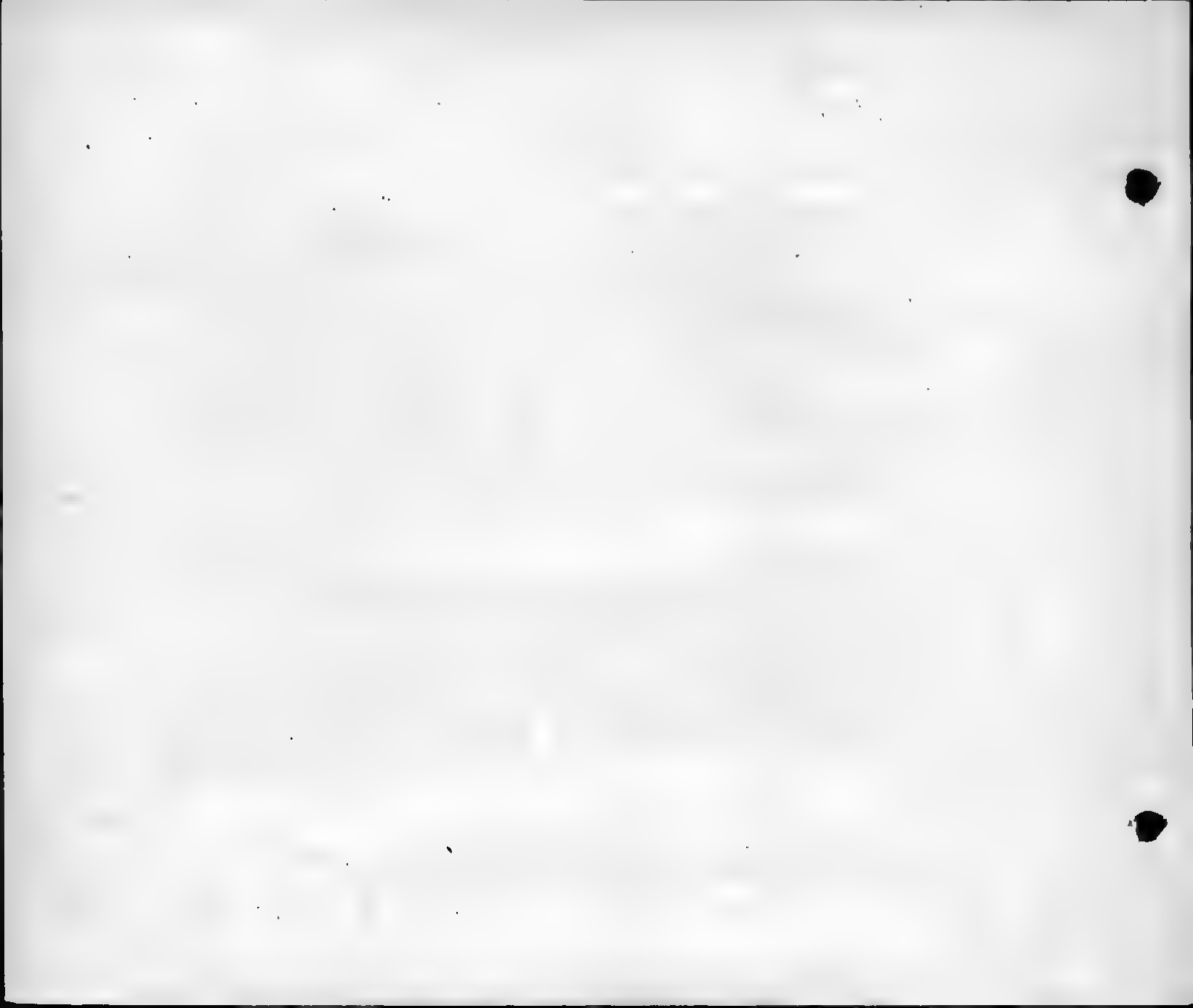
CERTIFICATE OF DEATH

14102

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>year</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTE ON <u>220 Hanville Drive</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>220 Hanville Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELL</u> Middle <u>A.</u> Last <u>McGEEVER</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1909</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 11. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Larned, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>John J. McGeever, (same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Cecum with</u> <u>175.5</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18-26 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1947 to 13 Dec. 1960</u> that (I) (we) last saw the deceased alive on <u>12 Dec 1960</u> and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. Add</u>		22b. DATE SIGNED <u>13 Dec 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM D. ADD</u>		22d. ADDRESS <u>7006 Calaveras Rd. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 16, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Add</u>		25a. REC'D BY REGISTRAR <u>DEC 16 '60</u>	
ADDRESS <u>254 Carroll St. No. 106</u>		25b. REGISTRAR'S SIGNATURE <u>William H. Add</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14161

14103

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Pittsburgh 32		d. STREET ADDRESS 5440 5th Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Dorothy McMurry		4. DATE OF DEATH Dec. 30		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7 1896		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Univ. of Pittsburgh		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Chas. A. Mc Murry		14. MOTHER'S MAIDEN NAME Emily Le. Cygne		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Donald Mc Murry		17. INFORMANT Ithica, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries DUE TO 816 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Driver of car which ran in rear of truck		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) highway		20c. TIME OF INJURY 12/30/60 9:10 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bethesda		20f. (City or town) (County) (State) Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/31/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 2, 1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.		23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



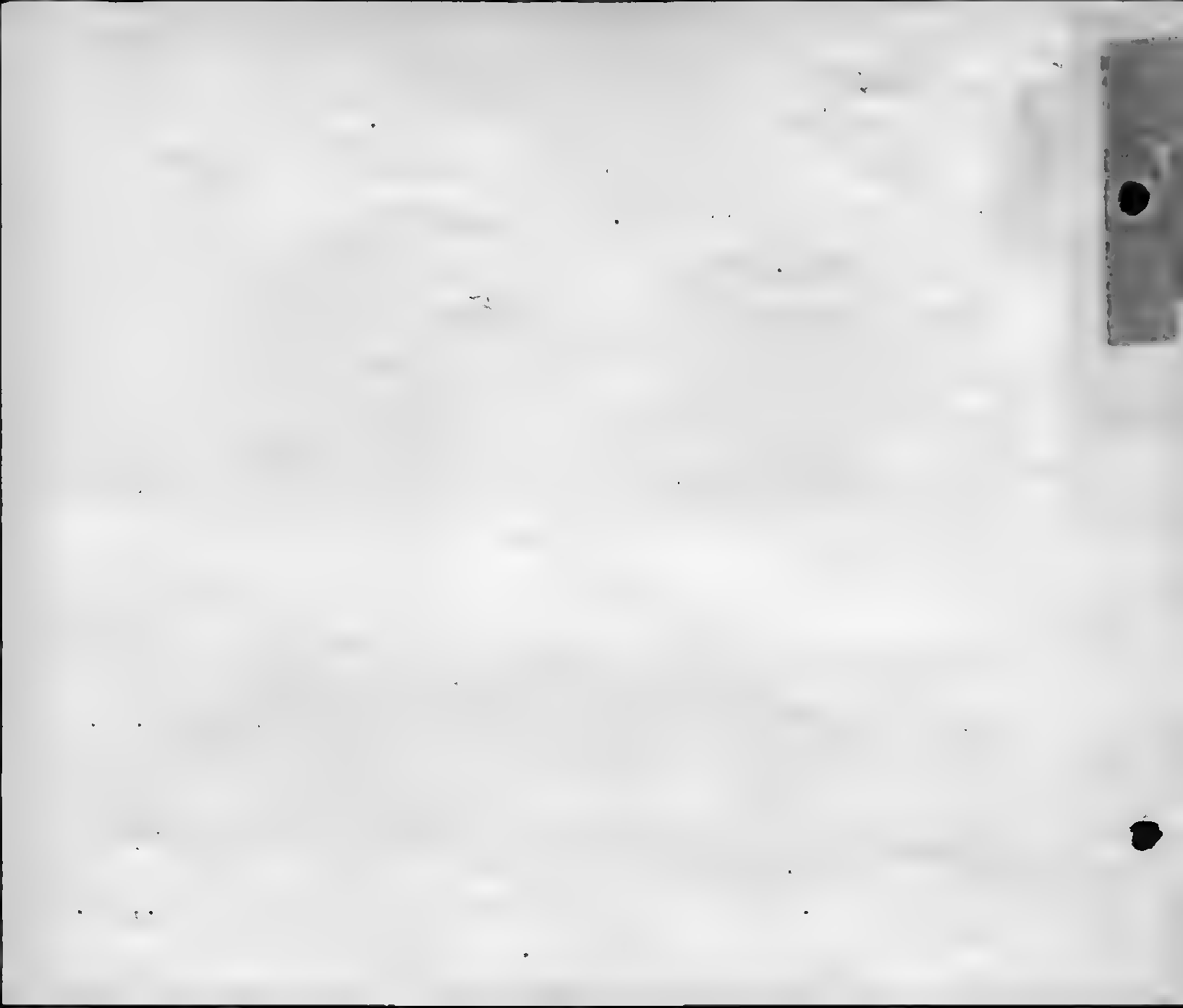
1
FOR STATE
HEALTH DEPT.

TO RETURN TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH e. COUNTY		2. Film G-279 1-23/61.		3. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		a. STATE		b. COUNTY	
Montgomery		MARYLAND		Pa.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Bethesda		DOA		Pittsburgh Pa.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburban Hospital				1830 K St., N.W.					
13. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year			
Ruth E. McMurry				12/30/60		19			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min.	
female		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/13/92		68 yrs.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
International Education				Illinois		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
Charles A. McMurry		Emilie Le Crone		no		Donald L. McMurry		1544 W. 17th St., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Multiple Traumatic Injuries				Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
				Passenger in car which ran in rear of truck		9:10 p.m. 12/30/60		White at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/>	
								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
								highway Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER	
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		DATE SIGNED					
Frank J. Broschart		Frank J. Broschart		12/31/60					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
Cremation		Jan. 2, 1961		Cedar Hill Crematory		Prince George Co., Md.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY		Bethesda, Md.		JAN 5 '61		William S. Kraus			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

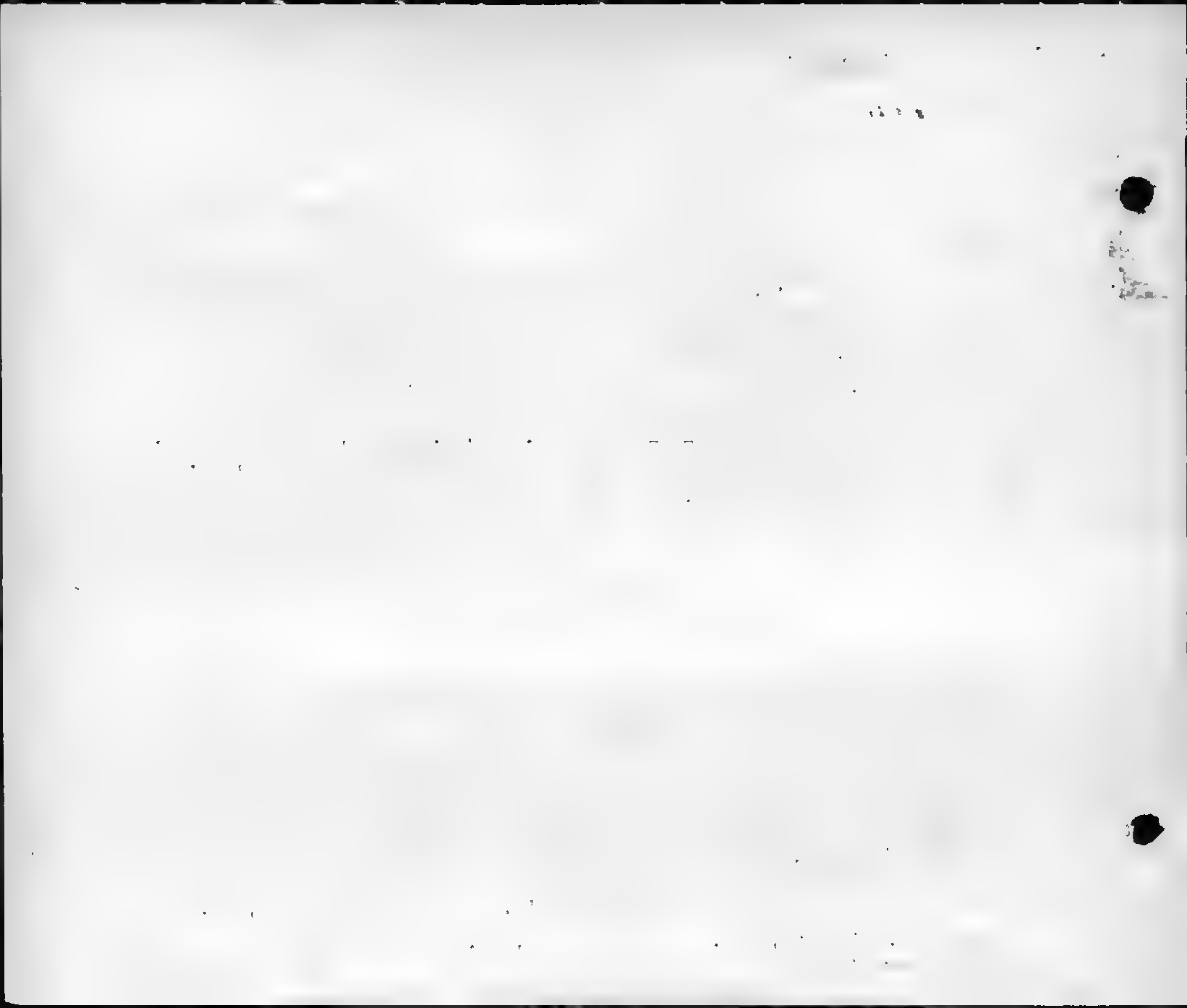
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14047

14105

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.A</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leash, SAN & Hosp</u>				d. STREET ADDRESS <u>2966 Weller Road</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Melton</u>				4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-91</u>	
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>ROBERT EDWARD MELTON</u>				14. MOTHER'S MAIDEN NAME <u>NANNIE PIERCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW #1 217-32-0737</u>		17. INFORMANT Mr. <u>Neva G. Melton</u> , 2906 Weller Rd. <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>1 June, 1959</u> to <u>11 Dec., 1960</u> that (I) (we) last saw the deceased alive on <u>28 Nov. 1960</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas P. Fogarty</u> M.D.				22b. DATE SIGNED <u>11 Dec 60</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>	
22d. ADDRESS <u>1011 Univ. Blvd E. Silver Spring, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u> </u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/14/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Funderburk, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>				25c. REGISTRAR'S SIGNATURE <u> </u>		25d. REGISTRAR'S SIGNATURE <u> </u>	



14163

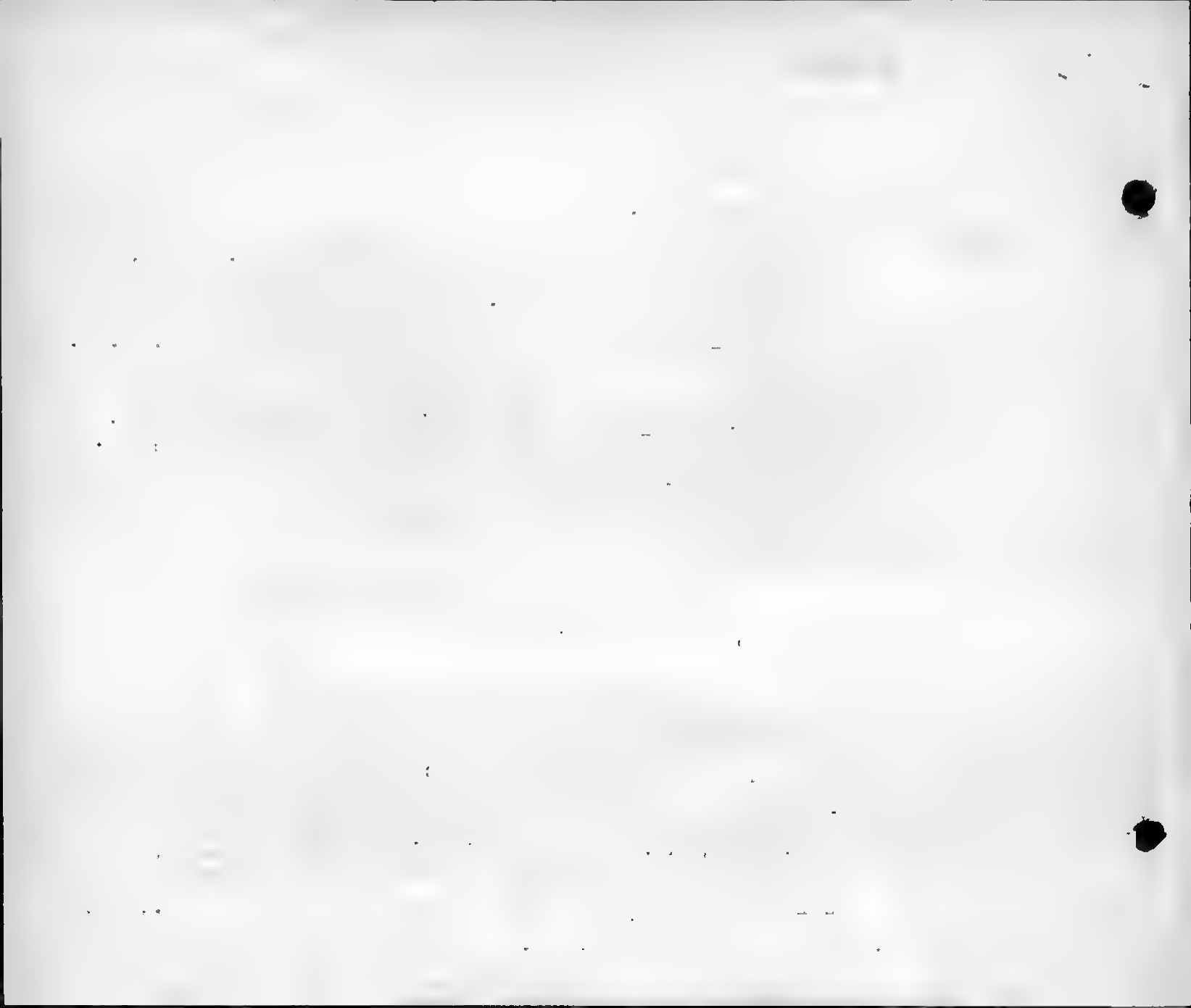
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14106

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 48	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4857 Battery Lane, Apt. 303		d. STREET ADDRESS 4857 Battery Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle M Last MICHELSON		4. DATE OF DEATH Month Dec. Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1878
9. AGE (in years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Conductor		10b. KIND OF BUSINESS OR INDUSTRY - Retired	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oscar Michelson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 337-03-4064	
17. INFORMANT Son		5205 Gretchen St. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric hemorrhage, cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1960 , to December 31, 1960 , that (I) (the) last saw the deceased alive on Dec. 31, 1960 , and that death occurred at 12:55 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. ADDRESS 5009 Del Ray Avenue, Bethesda, Maryland	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		22d. ADDRESS 5009 Del Ray Avenue, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1-2-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Jan 5 '61		25c. REGISTRAR'S SIGNATURE Jan 5 '61	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



14164

CERTIFICATE OF DEATH

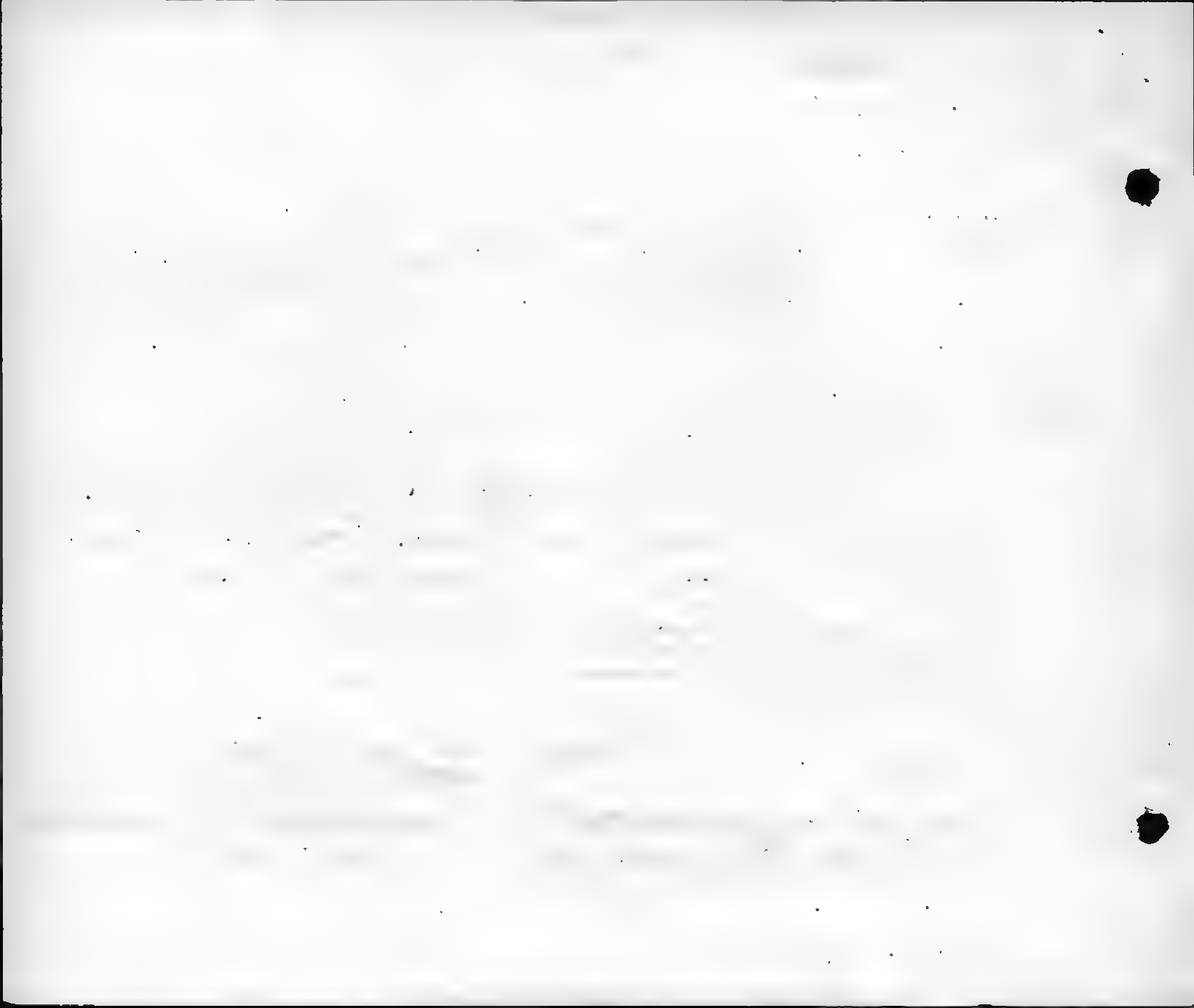
Reg. Dist. No.

14107

1 PLACE OF DEATH a. COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Guthrie Orchard Rural		c. LENGTH OF STAY IN 1b Guthrie Orchard Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 3 Gaithersburg		e. STREET ADDRESS R.F.D. # 3 Gaithersburg	
3 NAME OF DECEASED (Type or print) First Middle Last IDA AGN MILLS		4 DATE OF DEATH Month Day Year December 18 1960	
5 SEX Female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 22, 1906
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George Ward		14. MOTHER'S MAIDEN NAME Josephine Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO - - - - -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Pulmonary edema (b) Congestive heart failure (c) Hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ventral hernia, obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May, 1950, to Dec 18, 1960, that I last saw the deceased alive on Dec 16, 1960, and that death occurred 6:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John G. Fawcett M.D. DAWSONVILLE Dec 18, 1960 PHYSICIAN'S NAME (Type) JOHN G. FAWCETT M.D. P.O. BOYD, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/60	
22c. NAME OF CEMETERY OR CREMATORY Darnestown C. Co.		22d. LOCATION (City, town, or county) (State) Darnestown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tison Wheeler Funeral Home 1221 E. Montgomery Ave., Rockville, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 14108

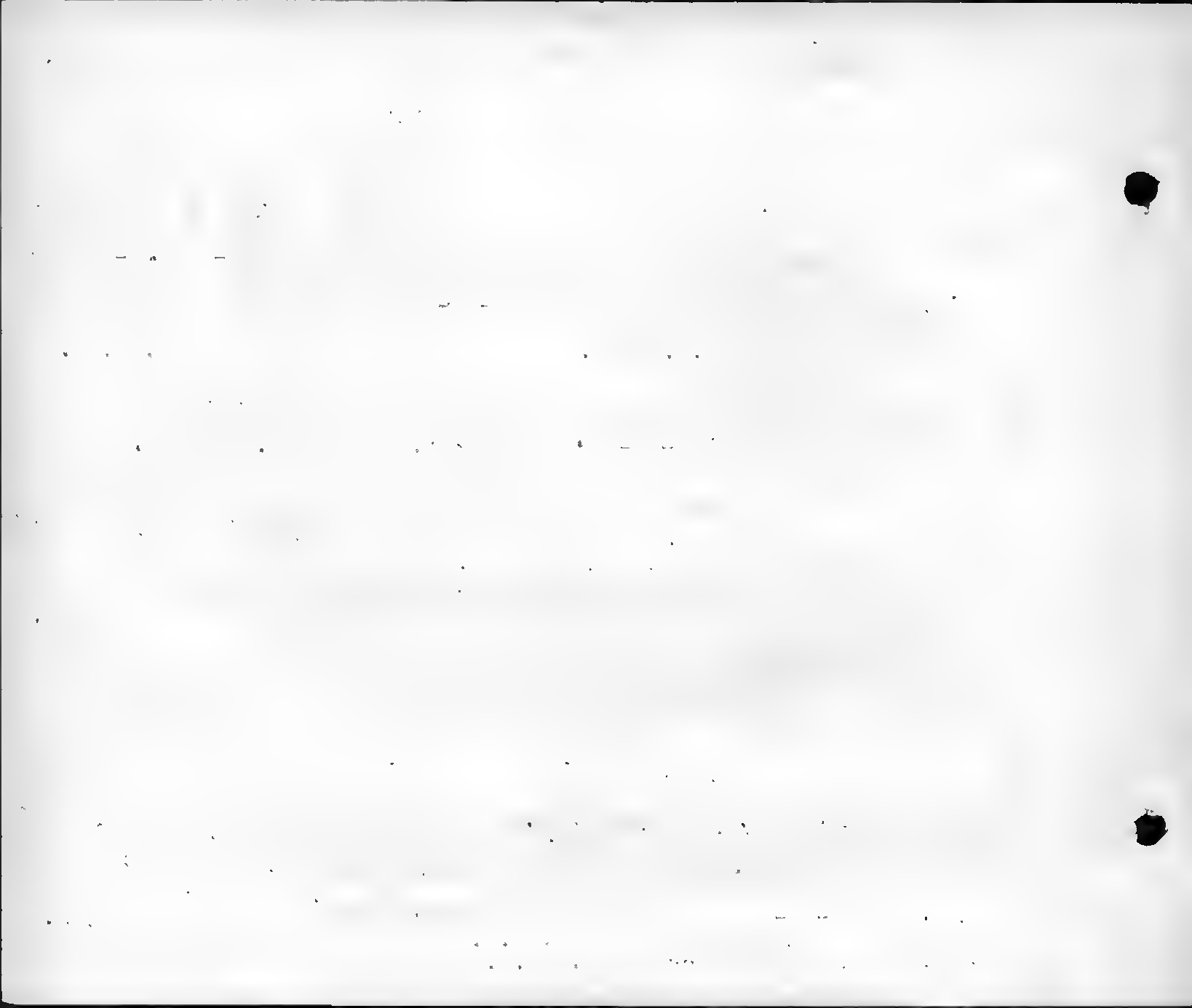
14013

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 4 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12033 BERRY STREET				d. STREET ADDRESS 12033 BERRY STREET			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET I MILLS				4. DATE OF DEATH Month Day Year 12-28-1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-96	9. AGE (In years lost birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ADDIS KRUSEN				14. MOTHER'S MAIDEN NAME MAUDE I. HUGHES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 577-56-6991		INFORMANT Address GEORGE P. MILLS, JR. SALE AS #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Carcinoma Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Melanomas Brain & Lungs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months 3 months						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11, 1960 to Dec 29, 1960 that I lost saw the deceased alive on Dec 29, 1960 and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10620 Georgia Ave 12/29/60 ACTUAL SIGNATURE John J. Curry PHYSICIAN'S NAME (Type) JOHN J. CURRY Silver Spring, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-31-60		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR DEC 30 '60		24b. REGISTRAR'S SIGNATURE Catharine S. House	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



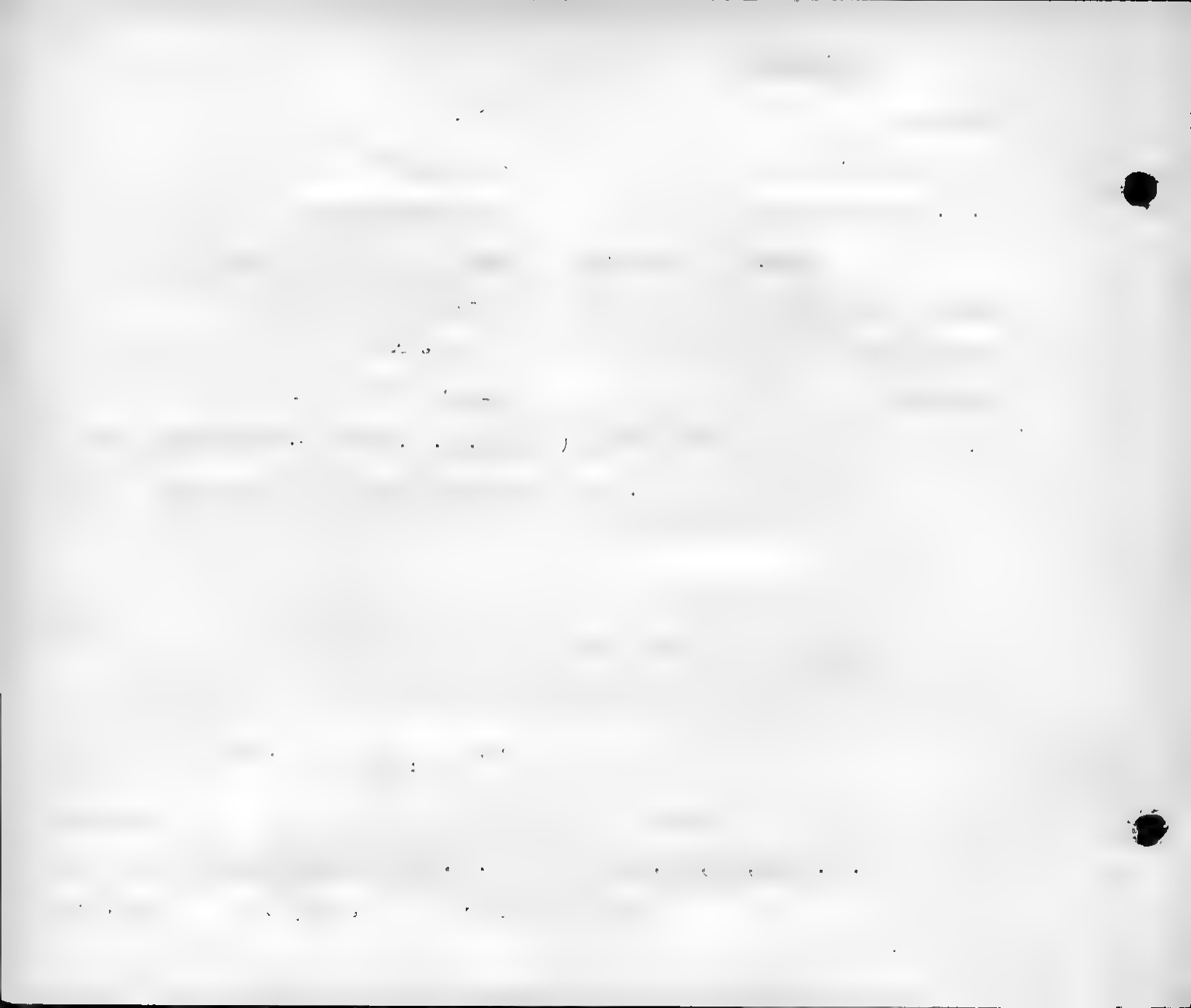
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14165

14109

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 6101 Merchant Road			
3. NAME OF DECEASED (Type or print) First Middle Last Marie Anastasia MOHL				4. DATE OF DEATH Month Day Year December 16 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-1889	
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Wife & Mother				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James HOEY				14. MOTHER'S MAIDEN NAME Margaret MC CAFFREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 087-16-9029		17. INFORMANT Address (S) Capt. E. V. Mohl, USN, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma, descending colon, with widespread metastases. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 153.2 DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 1/2 yrs INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from Oct. 12 1960 to Dec. 16 1960 , that (X) (we) last saw the deceased alive on Dec. 16 1960 and that death occurred at 12:35 PM M, from the causes and on the date stated above.							
22a. SIGNATURE R. G. Muth				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-16-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 12/19/60		23c. NAME OF CEMETERY OR CREMATORY Holy Name Cemetery		23d. LOCATION (City town or county) (State) Jersey City New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc				ADDRESS 3072 - M St NW Wash, D.C.		25a. REC'D BY REGISTRAR DATE DEC 22 '60	
				25b. REGISTRAR'S SIGNATURE C. J. S. Thoma			



14048

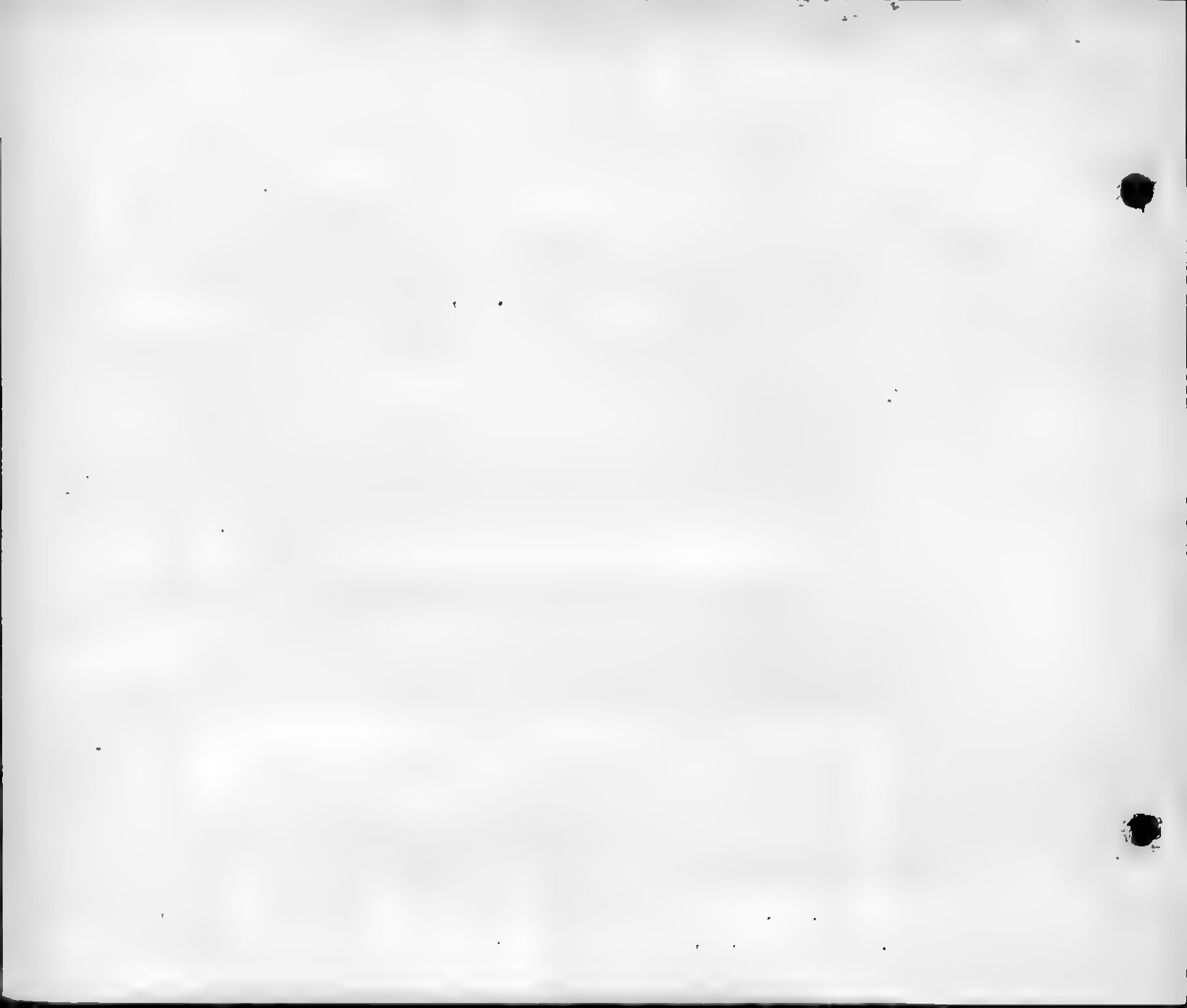
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14110

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>				c. LENGTH OF STAY IN 1b <u>18 days.</u>			
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital.</u>				d. STREET ADDRESS <u>1606 Bonifant St.</u>			
4. DATE OF DEATH First Middle Last <u>DONALD O'DEAN MONTGOMERY</u>				4. DATE OF DEATH Month Day Year <u>DEC 14 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1921</u>	9. AGE (In years lost birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Franko. Montgomery</u>				14. MOTHER'S MAIDEN NAME <u>Helen Kinsella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>yes - 1942-44</u>		16. SOCIAL SECURITY NO. <u>523-07-5547</u>		17. INFORMANT Address <u>Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Antero-septal myocardial infarction</u> DUE TO <u>Arteriosclerotic cardiovascular-renal disease</u> (b) <u>42 years old</u> DUE TO <u>gave rise to immediate cause (a), stating the underlying cause last</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 d.</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NO</u>					
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2 1960</u> to <u>Dec 14 1960</u> , that <u>it</u> (was) last saw the deceased alive on <u>Dec 14 1960</u> , and that death occurred at <u>5:14 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William F Simpson, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F Simpson Jr</u>				22d. ADDRESS <u>6216 N.H. Ave. N.E. - D.C.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 19, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc. Silver Spring, MD.</u> <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR <u>DATE DEC 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Thomas</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14166

CERTIFICATE OF DEATH

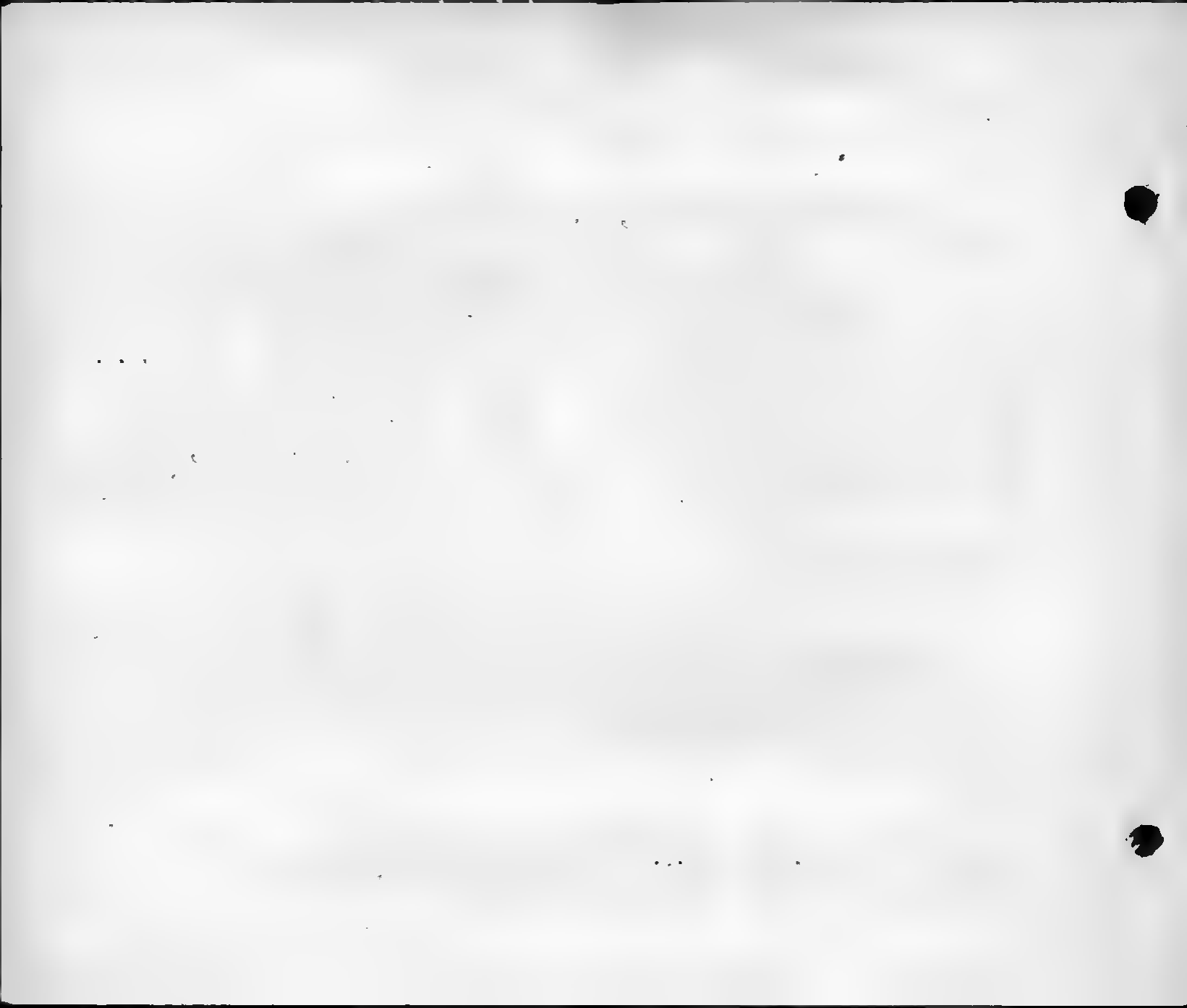
14111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 61 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1404 Annapolis Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Denise Loretta Moog				4. DATE OF DEATH Month Day Year December 11 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1951	
9. AGE (In years lost birthday) 9 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Otis Moog				14. MOTHER'S MAIDEN NAME Geraldine Poehlitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neuroblastoma with Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 12 Months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3:45A	
20f. (City or town) Bethesda				20g. (County) Montgomery			
21. I certify that I attended the deceased from October 11, 19 60 , to December 11, 19 60 , that I last saw the deceased alive on December 11, 19 60 , and that death occurred at 3:45A M, from the causes and on the date stated above							
ACTUAL SIGNATURE Edward E. Morse				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Edward E. Morse, M.D.				DATE SIGNED 12/11/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 12-15-60		22c. NAME OF CEMETERY OR CREMATORY Clon Haven	
22d. LOCATION (City, town, or county) Clon Haven, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Tickner's F. H., Balto., Md.				24a. REC'D BY REGISTRAR DATE DEC 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

141167

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14112

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Cabin John			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6521-75th Street				d. STREET ADDRESS 6521-75th Street			
e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Martha Middle E Last Morgal		4. DATE OF DEATH Month December Day 17 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1885				
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR 7 Months 3 Days 3 Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----					
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME David L. Beall		14. MOTHER'S MAIDEN NAME Annie Walker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None					
17. INFORMANT Ralph L. Morgal-son-same 2d		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last, (b) Cirrhosis Vascular Heart Disease DUE TO (c) 10 YRS INTERVAL BETWEEN ONSET AND DEATH 3 YRS 10 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 1950 to Jan 1960 , that (I) (we) last saw the deceased alive on Dec 14 1960, and that death occurred at 2:30 M, from the causes and on the date stated above							
22a. SIGNATURE Leo I. O'Connell M.D.		22b. DATE SIGNED 12/17/60					
22c. PHYSICIAN'S NAME (Type) Leo I. O'Connell M.D.		22d. ADDRESS 8218 WISCONSIN AVE BETHESDA 14 MD					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/60					
23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		23d. LOCATION (City, town, or county) (State) Potomac, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REG STRAR DATE DEC 21 '60					
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline					



14168

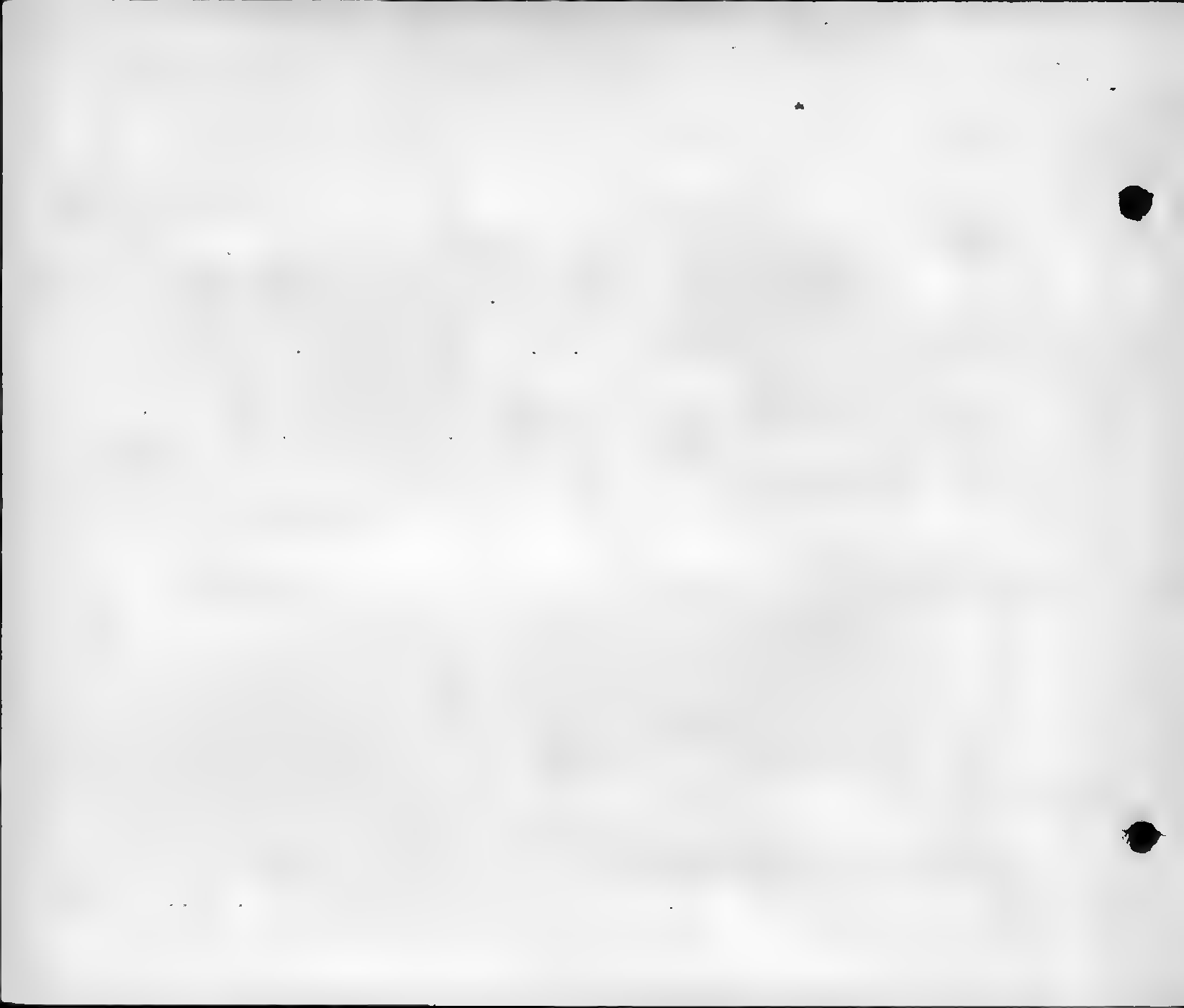
CERTIFICATE OF DEATH

Reg. Dist. No.

14113

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7100 Oak Forest Lane		d. STREET ADDRESS 7100 Oak Forest Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANDREW Middle J Last MORRIS		4. DATE OF DEATH Month Dec. Day 31 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR: Months 4 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Southern R. R.	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace Morris		14. MOTHER'S MAIDEN NAME Nellie Bain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Andrew J. Morris, Jr.--son		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) myocardial Infarction 1951		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April, 1943 to Dec. 31, 1960 , that I last saw the deceased alive on Dec. 30, 1960 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Gilbert B Rude M.D. 3900 Military Rd. N.W. 12/31/60		K.C.	
PHYSICIAN'S NAME (Type) Gilbert B Rude			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/61	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Geo. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE AN 3 '61	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



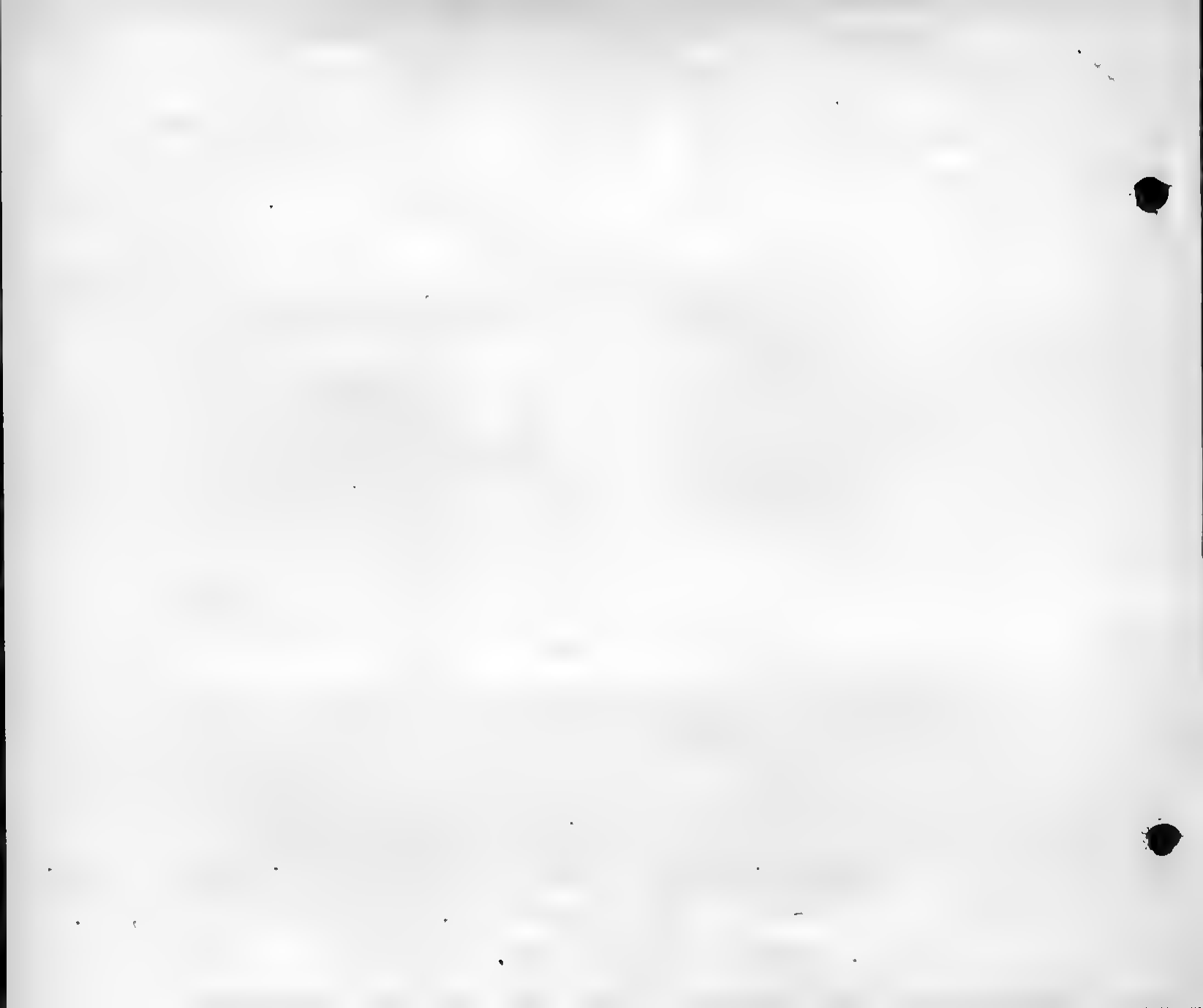
14169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14114

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sulurban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>WINIFRED S. MULCAHY</i>		4. DATE OF DEATH <i>Dec. 2, 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 8, 1914</i>
9. AGE (In years last birthday) <i>46 yrs.</i>		10. IF UNDER 1 YEAR: Months <i>12</i> Days <i>2</i> Hours <i>0</i> Min <i>0</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Fred N. Stuart</i>	
14. MOTHER'S MAIDEN NAME <i>Louise Booker</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Husband (Bertram Mulcahy) Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i> 3.30 X DUE TO <i>Essential hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(c)</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 mos</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 12/2</i> 19 <i>60</i> , to <i>12/2</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>12/2</i> 19 <i>60</i> , and that death occurred at <i>6:15 AM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Horace W. Bernton</i> M.D.		22b. DATE SIGNED <i>12/2/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Horace W. Bernton</i>		22d. ADDRESS <i>10511 Summit Ave., Kensington, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-6-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Montgomery County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>DEC 6 '60</i>	
ADDRESS <i>Bethesda, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 1 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

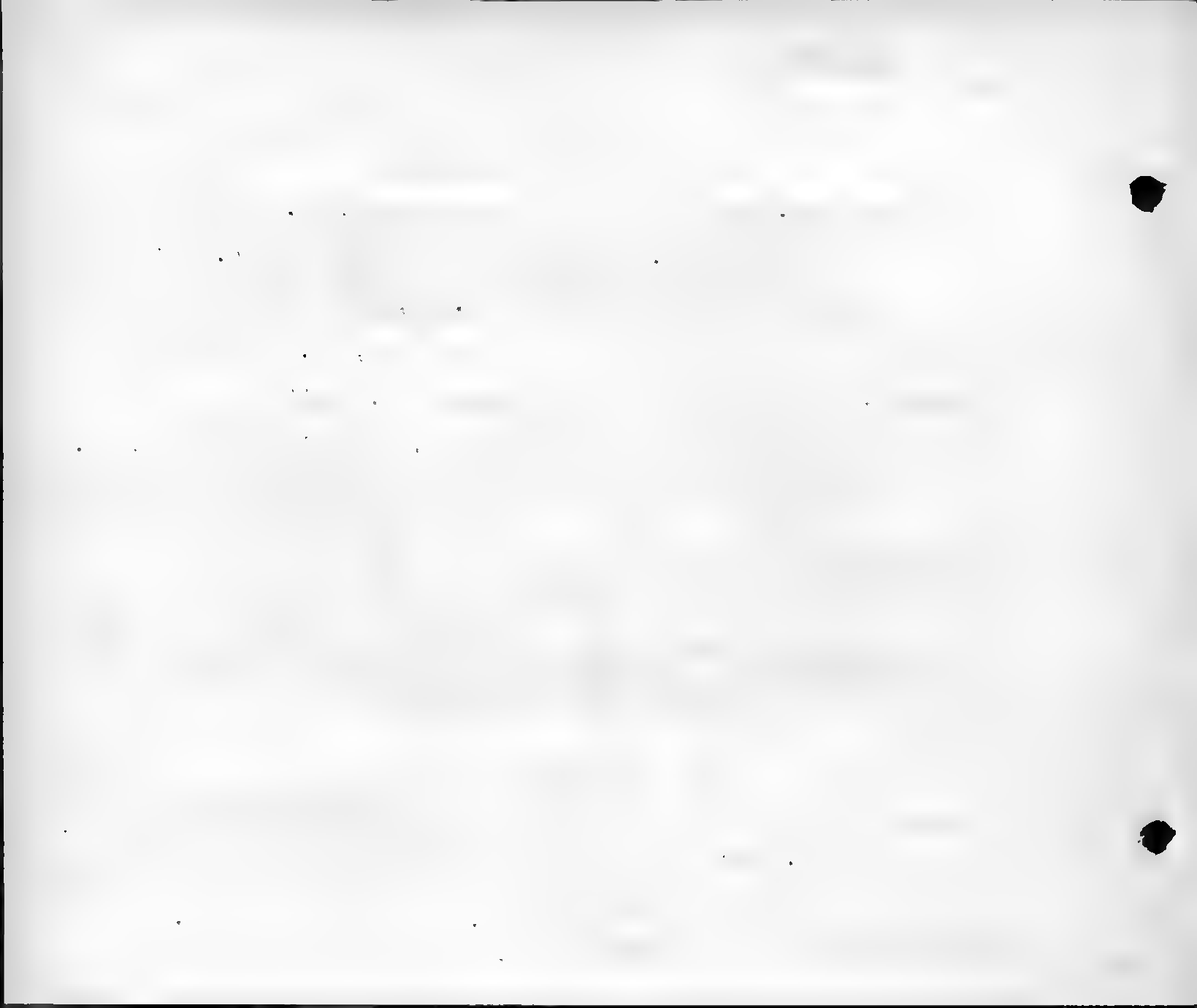
14115

14170

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9514 Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>G.</u> Last <u>Mullinix</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Clarksburg, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George W. Hilton</u>				14. MOTHER'S MAIDEN NAME <u>Frances C. Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		INFORMANT <u>William M. Mullinix, Damascus, Md.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15, 1942</u> to <u>12/19, 1960</u> that I last saw the deceased alive on <u>12/17, 1960</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, State) <u>Damascus, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>				DATE SIGNED <u>12/19/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin L. Wicks</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

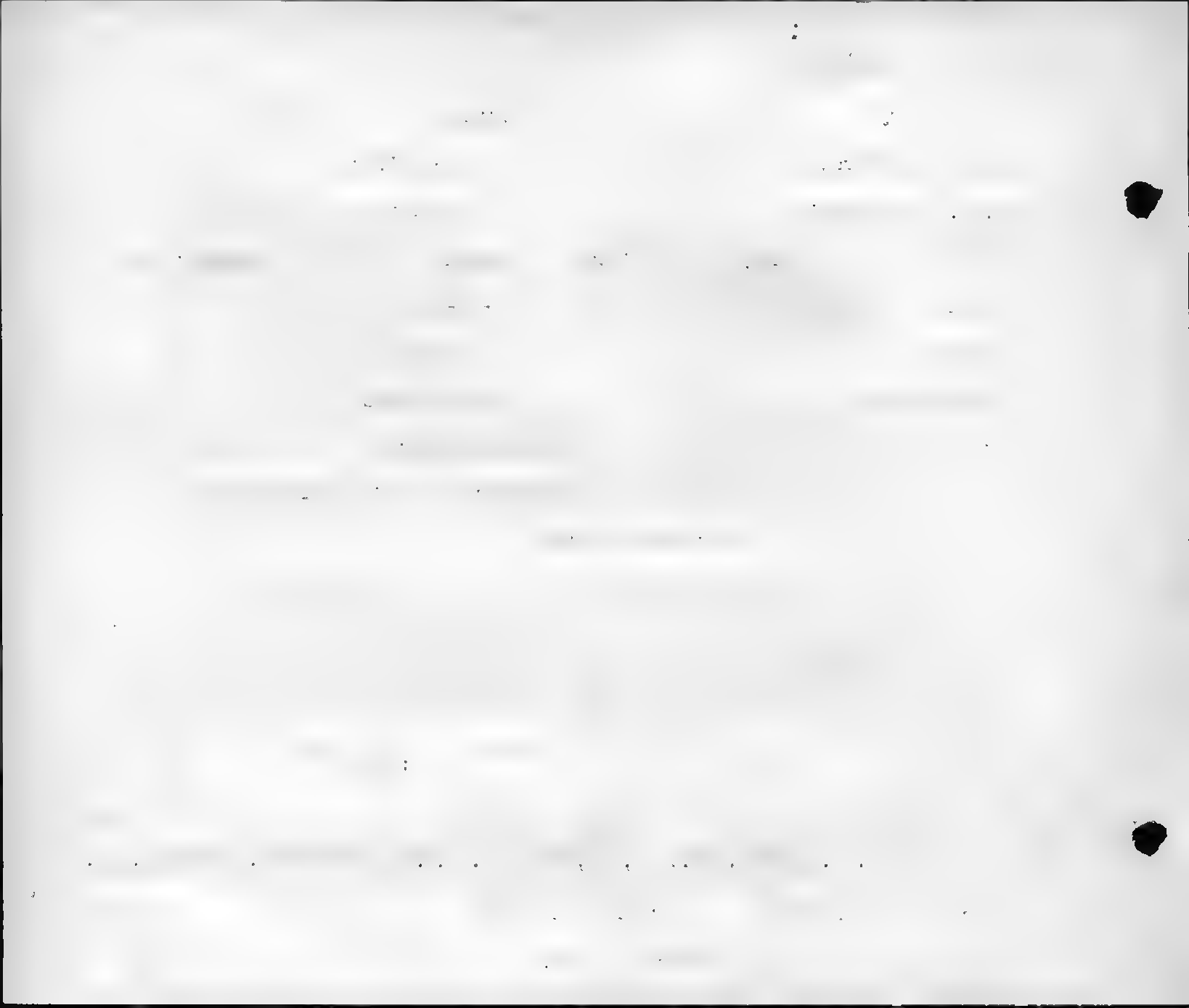


VR A15 (4)
15M 9/59

14116

14171

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 107 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 710 MEMO, Naval Air Station		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Gladys		Middle O'Neal		Last MURPHY	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-18	
9. AGE (In years last birthday) 42		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME Otis GOODSON		14. MOTHER'S MAIDEN NAME Shulia HOWELL		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage, site undetermined							
17IX DUE TO (b) Carcinoma, cervix							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Sept. 8, 1960 to Dec. 24, 1960 , that (a) (we) lost saw the deceased alive on Dec. 24, 1960 , and that death occurred at 6:05 PM M, from the causes and on the date stated above.							
22a. SIGNATURE Arthur S. Anctil, Jr. M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-25-60	
22c. PHYSICIAN'S NAME (Type) A. O. ANCTIL, JR., LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Matthews Funeral Home				ADDRESS Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



14172

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14117

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				d. STREET ADDRESS <u>15501 Albemarle St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Mary Murray</u>				4. DATE OF DEATH <u>Dec. 2, 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1888</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>14</u>	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Residence</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick Murray</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Mc. Nulty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. James Murray</u>		Address <u>5501 Albemarle Wash. D.C. St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> 153.3 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of Tris</u> DUE TO _____ (c) <u>Carcinoma of sigmoid</u> DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1960</u> to <u>Dec 2</u> , 1960, that (I) (we) last saw the deceased alive on <u>Dec 20 1960</u> and that death occurred at <u>15501</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Murphy</u> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. MURPHY M.D.</u>				22d. ADDRESS <u>1801 EYE ST NW WASHINGTON D.C.</u>			
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c. DATE THEREOF <u>DEC. 5, 1960</u>		23d. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23e. LOCATION (City, town, or county) <u>Chicago, Illinois</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Dole</u> ADDRESS <u>2224 Wisconsin Wash D.C.</u>				25. REC'D BY REGISTRAR DATE <u>DEC 7 '60</u>		26. REGISTRAR'S SIGNATURE <u>C. J. Frank</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Her death

Page 4

General director

IRIAN: The law too

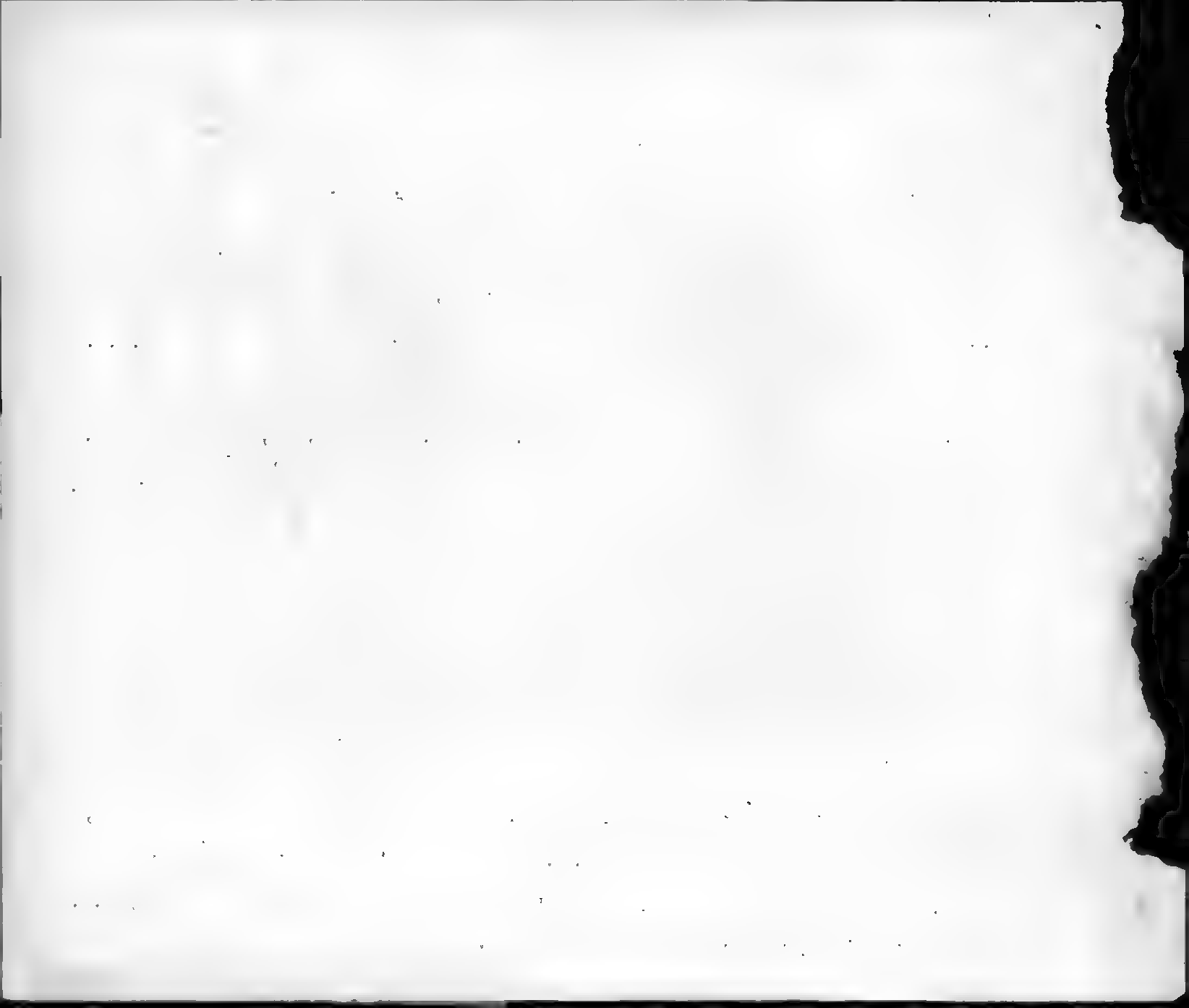
CERTIFICATE OF DEATH

Reg. Dist. No.

14118

14014

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE NEW YORK b COUNTY NEW YORK	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b 4 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lebeau Gardens Nursing Home		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW YORK	
3 NAME OF DECEASED (Type or print) Frank (NMI) Neubauer		4 DATE OF DEATH Month December Day 13 Year 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated	8 DATE OF BIRTH MAY 11, 1901
9 AGE (In years last birthday) 59 yrs.		10 IF UNDER 1 YEAR: Months 59 Days 59 Hours 59 Min 59	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO yes	
17 INFORMANT Mrs. John W. Neubauer, 11,941 Bluhill Rd.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrotherox, 1st 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Carcinomatosis DUE TO (c) Carcinoma of the Stomach		INTERVAL BETWEEN ONSET AND DEATH 7 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from Dec 12, 1960 to Dec 13, 1960 , that I last saw the deceased alive on Dec 13, 1960 , and that death occurred at 11:00 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert T. Thibodeau		ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Dec 13, 1960	
PHYSICIAN'S NAME (Type) Robert T. Thibodeau, M.D.		K. sington, Maryland	
22a BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
TRANS. & BURIAL	12/17/60	ST. MICHAEL'S CEMETERY	ASTORIA, LONG ISLAND, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, INC.		24a. REC'D BY REGISTRAR DATE DEC 19 60	
ADDRESS SILVER SPRING, MD.		24b REGISTRAR'S SIGNATURE James A. Rusk	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14070

Reg. Dist. No. 14119

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Rural</u>	
c. LENGTH OF STAY IN 1b <u>D.A.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box Car B+O R R</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irma Effie Nicholson</u>		4. DATE OF DEATH <u>Dec 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1912</u>
9. AGE (In years last b. today) <u>48</u> yrs		10. IF UNDER 1 YEAR Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Henry T. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Emma B. Day</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>William E. Nicholson Gaithersburg, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute embolism with alveolar ruptures</u> 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Intervalveolar hemorrhages</u> (c) <u>Acute Alcoholism</u> (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crestwood National</u>		22d. LOCATION (City, town, or county) (State) <u>Crestwood Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank E. Johnson Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>William E. Nicholson</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>DEC 7 '60</u>	

DATE SIGNED

12-3-60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14120

14071

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>6 mo</u>		d. STREET ADDRESS <u>431 N. Frederick Ave. Apt. 102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>431 N. Frederick Ave. Apt. 102</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruben Young Nicholson</u>		4. DATE OF DEATH <u>Dec 2 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-21</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Stock Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm Young Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Bowring</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO <u>212-20-2219</u>	
17. INFORMANT <u>Elsie Nicholson - Sister</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction left ventricular wall</u>			
420.1 DUE TO (b) <u>Coronary Thrombosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary Atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Unknown</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bruschat</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		24a. REC'D BY REGISTRAR <u>Arthur J. Kline</u>	
ADDRESS <u>Laytonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	
DATE <u>DEC 7 '60</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



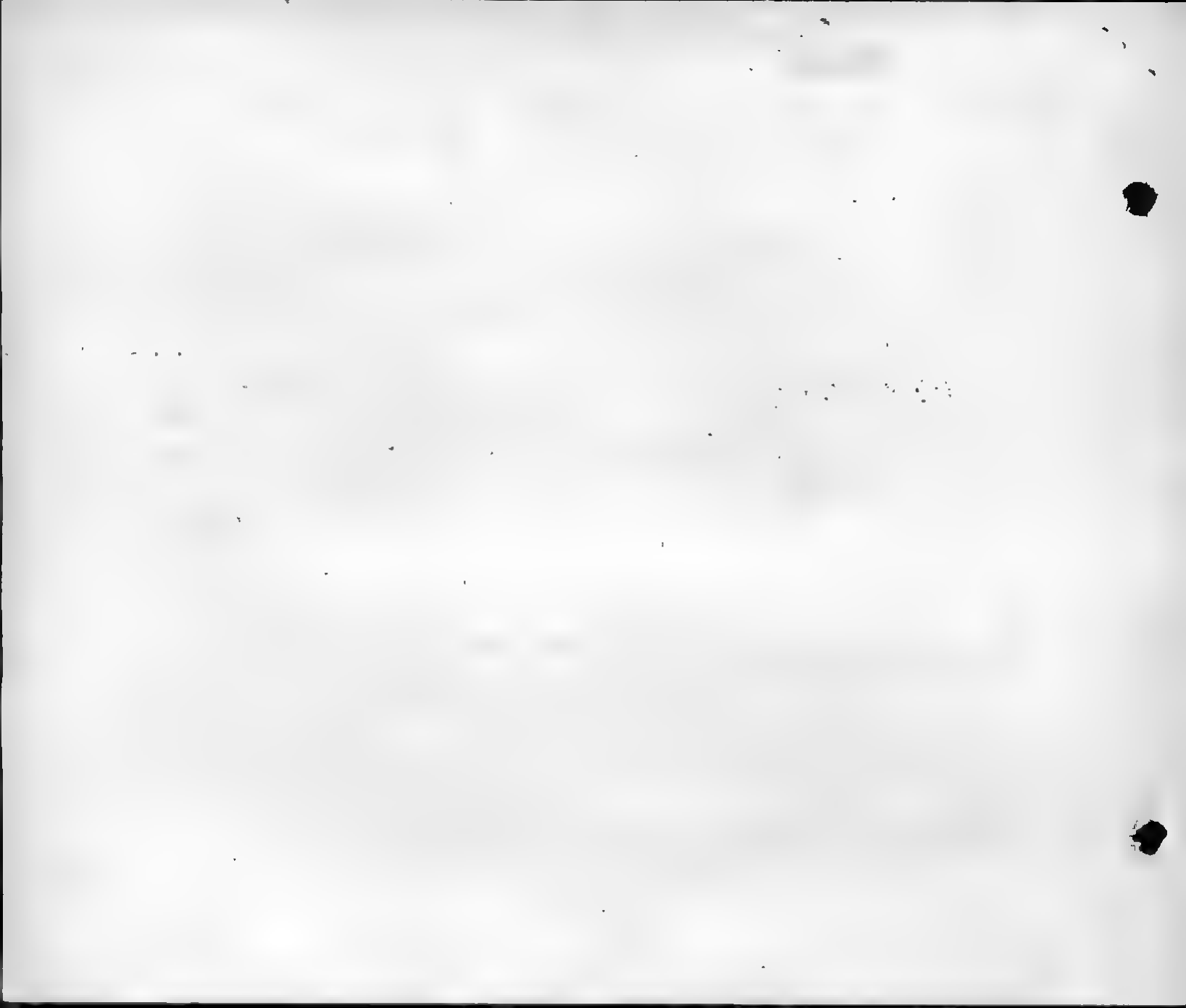
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14121

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Jersey b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook d. STREET ADDRESS 802 East Parsonage Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kanesuke Middle Last Nishimoto				4. DATE OF DEATH Month 12 Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE Y		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/84	
9. AGE (in years, last birthday) 76 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gardener		11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? U.S.A. for 5 yrs.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Ochika Kawanoto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 137-22-7171		17. INFORMANT Address Tsutomu Nishimoto Ito			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, recent, 420.1 DUE TO (b) Coronary thrombosis, left descending apex DUE TO (c) Coronary atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4:00 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/6/60 to 12/6/60 , that (I) (we) last saw the deceased alive on 12/6/60 , and that death occurred at 12/6/60 M. from the causes and on the date stated above.							
22a. SIGNATURE James McCorrie M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/6/60	
22c. PHYSICIAN'S NAME (Type) James McCorrie				22d. ADDRESS 3721 Leland St., Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/10/60		23c. NAME OF CEMETERY OR CREMATORY Silverbrook		23d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE Lyson Wheeler Funeral Home ADDRESS E. Baltimore Ave. Rockville, Md.				25a. REC'D BY REGISTRAR DEC 9 '60		25b. REGISTRAR'S SIGNATURE John S. Kline	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

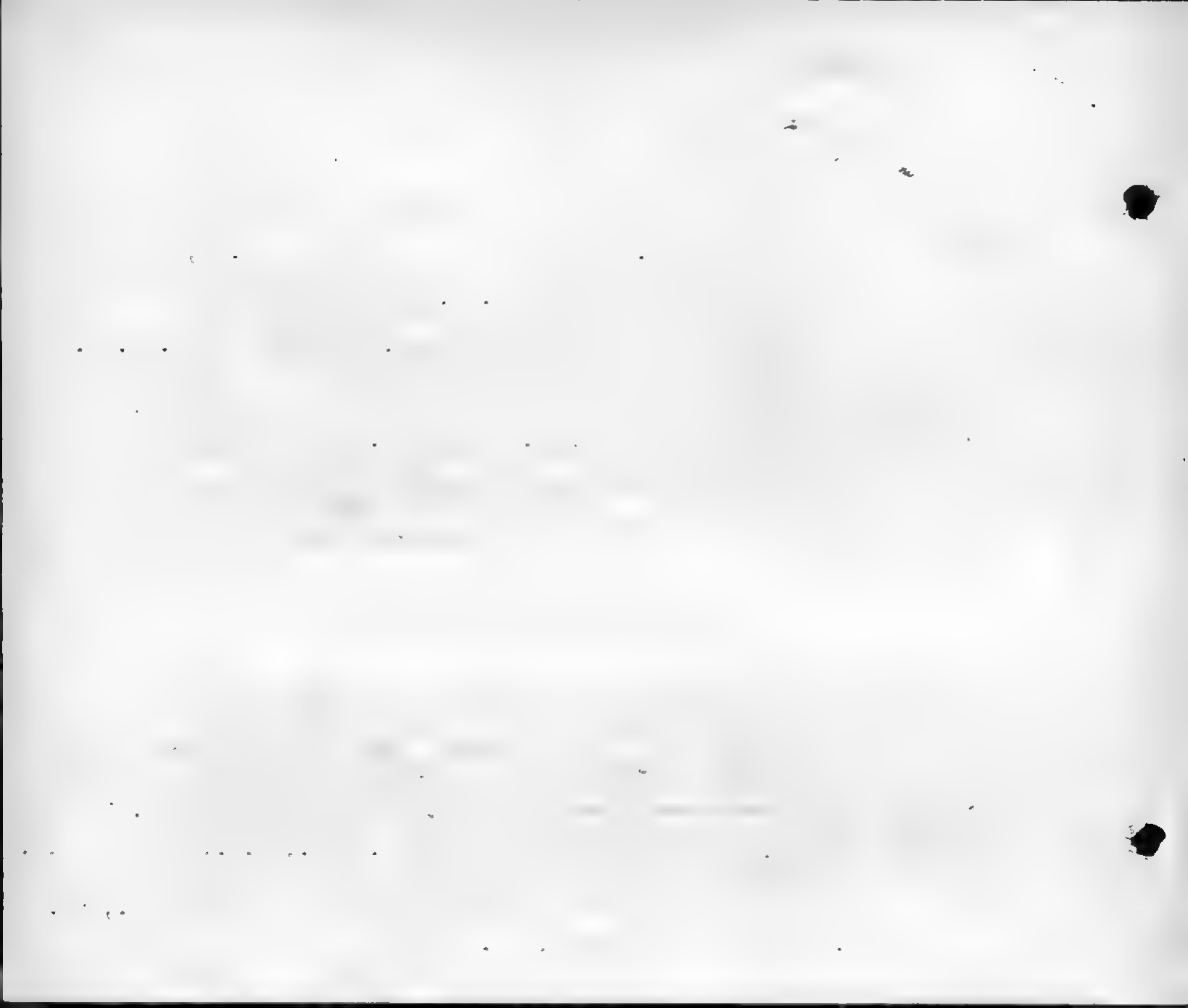
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14174

CERTIFICATE OF DEATH

14122

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield Manor				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5400 Christy Drive				d. STREET ADDRESS 5400 Christy Drive			
3. NAME OF DECEASED (Type or print) GEORGE H. NORRIS				4. DATE OF DEATH Month Dec. Day 2 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1886		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months 1 Days 5	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Norris				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 577-10-9156		17. INFORMANT Daughter Mrs. Bernice N. Kirkpatrick		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 420. Acute myocardial infarction DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Prince George Co., Md.		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 1950 to Dec 2, 1960 , that (I) (we) last saw the deceased alive on Dec 1, 1960 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. McMahon				22b. DATE Dec. 2, 1960		22c. PHYSICIAN'S NAME (Type) THOMAS F. McMAHON	
22d. ADDRESS 3000 Conn. Ave., N.W., Washington, D.C.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/5/60	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DEC 6 '60	25b. REGISTRAR'S SIGNATURE William S. Evans

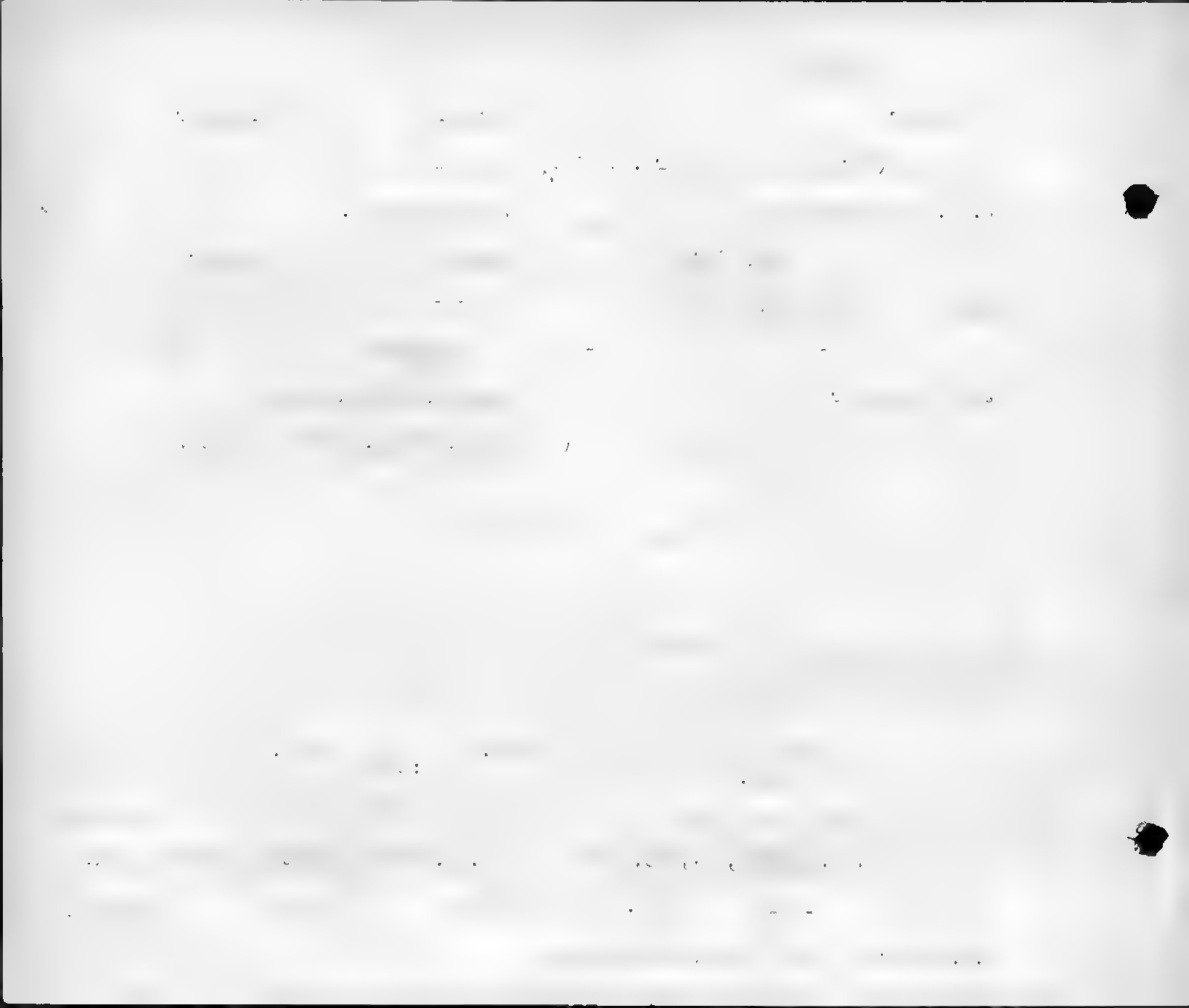


VR A1S (4)
ISM 9/59

14123

14175

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2hrs. 44min.		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 4403 Maple Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		First OATES		Middle OATES		Last OATES	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month December Day 8 Year 1960	
9. AGE (In years last birthday) 12-8-60		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Alexander OATES		14. MOTHER'S MAIDEN NAME Meredith STRINGFIELD		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT (F) John A. Oates, same as #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis DUE TO (b) Immaturity DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 8, 1960 to Dec. 8, 1960 that (I) (we) lost saw the deceased alive on Dec. 8, 1960 and that death occurred at 7:10PM from the causes and on the date stated above		22a. SIGNATURE F. W. Grello		22b. DATE SIGNED 12-9-60		22c. PHYSICIAN'S NAME (Type) F. W. GRELLO, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-10-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hills Crematory	
23d. LOCATION (City, town, or county) (State) Suitland Maryland		24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a. REC'D BY REGISTRAR DATE DEC 12 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	



CERTIFICATE OF DEATH

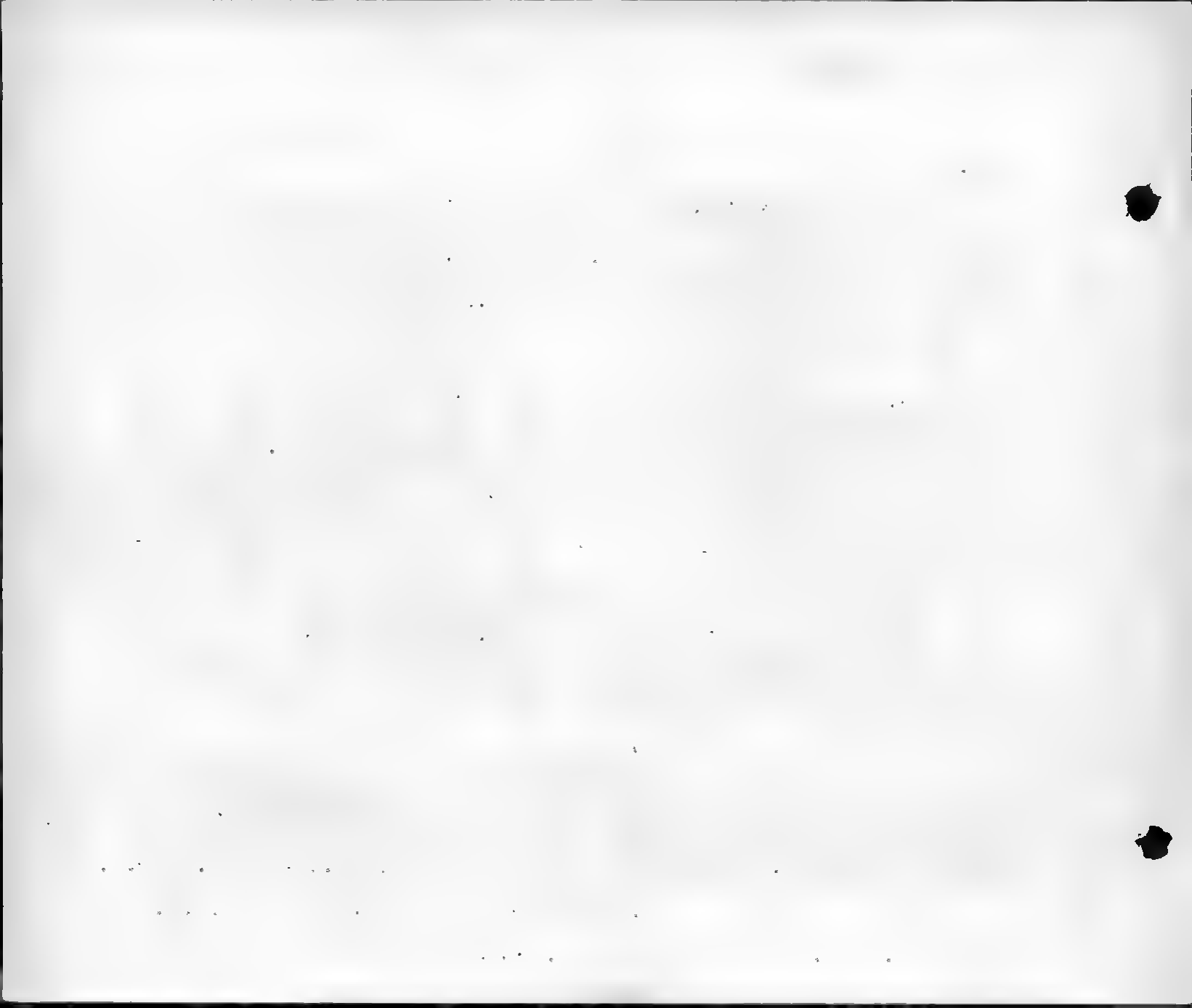
Reg. Dist. No. 14124

14065

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Summerfield Road		d. STREET ADDRESS 113 Summerfield Road	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle M. Last O'DONNELL		4. DATE OF DEATH Month December Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1871
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Denis Long		14. MOTHER'S MAIDEN NAME Johanna Donoghue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
INFORMANT Julia O'Donnell-#2d.		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cerebral Vascular Ischemia 2 yrs 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 20 yrs DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Myocardial Ischemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1-55 , 19 10 , to 12-28-60 , 19 60 , that I last saw the deceased alive on 12-28-60 , 19 60 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew J. Betz		ADDRESS (Street, city or town, state) 5412 Colo. Ave NW Wash D.C.	
PHYSICIAN'S NAME (Type) Andrew J. Betz, M.D.		DATE SIGNED 5412 Col. Ave., NW Wash. 11, D.C.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE DC3	
24a. REC'D BY REGISTRAR DEC 30 '60		24b. REGISTRAR'S SIGNATURE Andrew J. Betz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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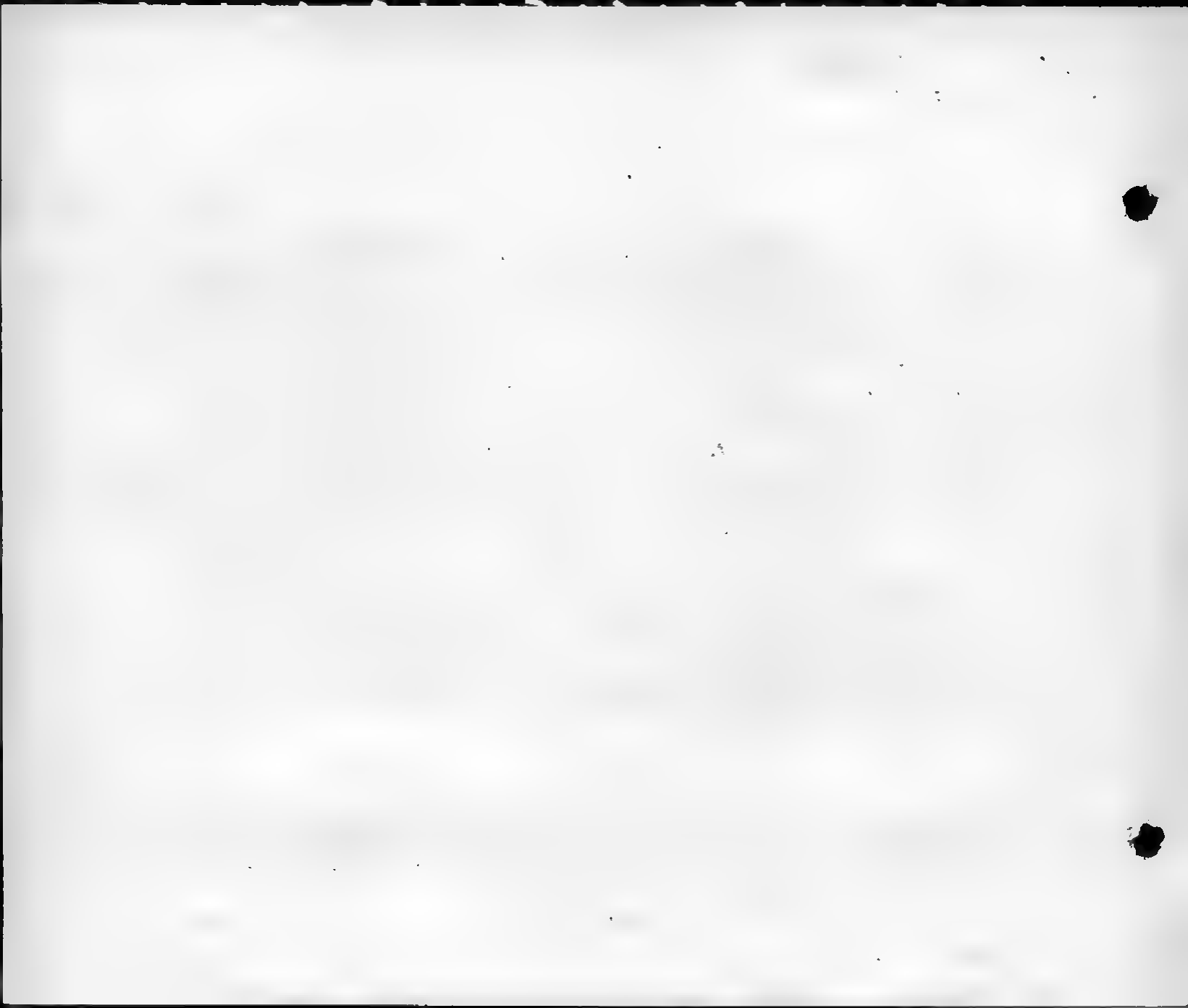
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14049 CERTIFICATE OF DEATH 14125

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b <u>3 hours</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>19118 Kirkdale Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert NMN Oelschlaeger</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/9/85</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>7</u> Hours <u>19</u> Min.		IF UNDER 24 HRS Hours <u>19</u> Min.			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>statistician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CIT ZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Oelschlaeger</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>136-01-0286</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <u>4. Congestive Heart Failure</u> DUE TO Arteriosclerotic Cardiovascular Disease DUE TO Disease DUE TO Disease							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Angina Pectoris</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 5, 1960</u> to <u>Dec 7, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 7, 1960</u> and that death occurred on <u>Dec 7, 1960</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George B. Patrick Jr</u> M.D.				22b. DATE SIGNED <u>12-7-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>George B. Patrick, Jr MD</u>				22d. ADDRESS <u>9221 Collesville Rd Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>12/10/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Restland Mem. Prk</u>		23d. LOCATION (City, town, or county) (State) <u>Hanover, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>Behtesda, Maryland</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				DATE <u>12 DEC 8 '60</u>			



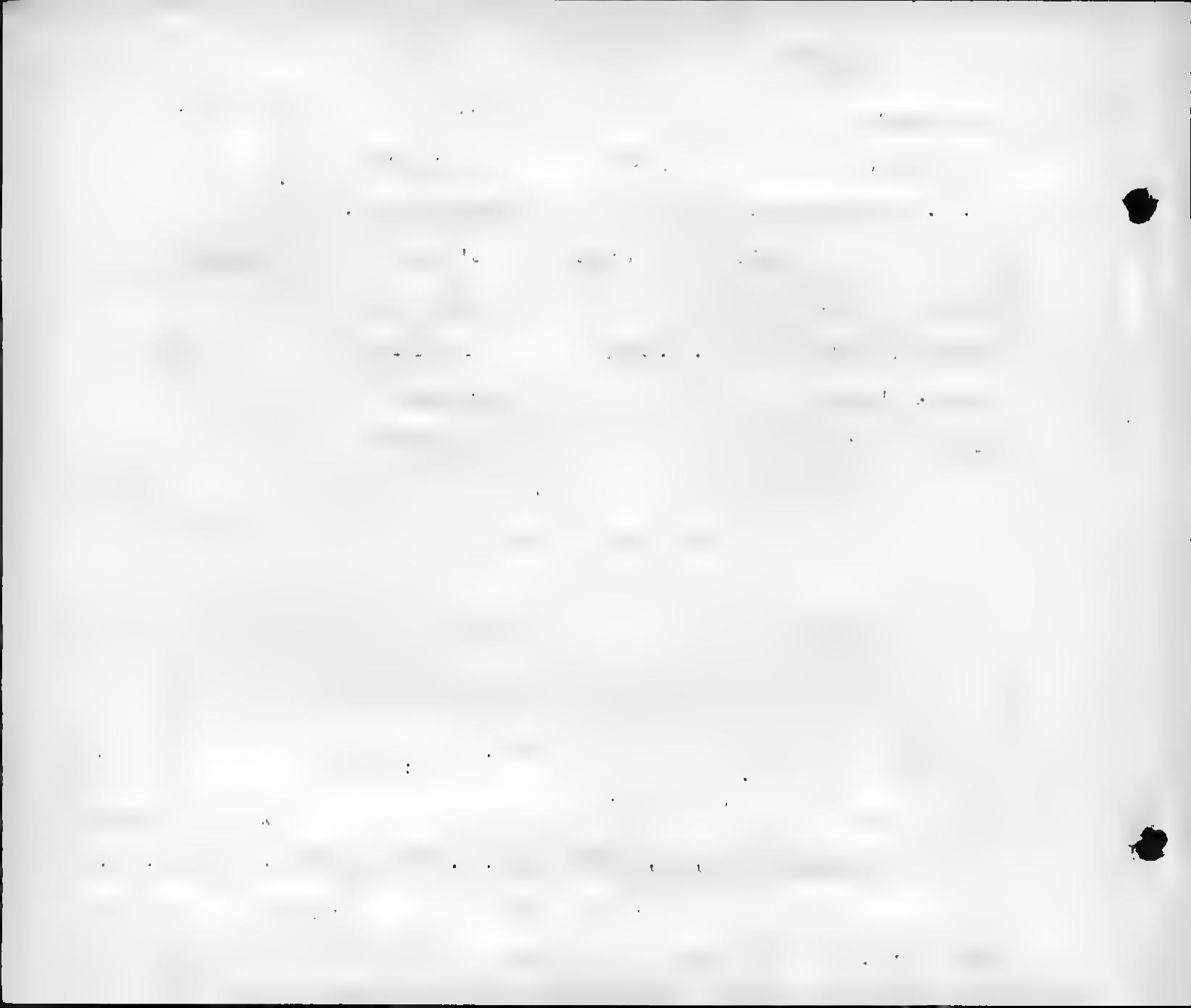
14176

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14126

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						d. STREET ADDRESS 402 Mills Ave.					
3 NAME OF DECEASED (Type or print) Neil James O'HARA			First Middle Last			4 DATE OF DEATH December 6 19 60			Month Day Year		
5 SEX Male		6 COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-96		9 AGE (In years last birthday) 64 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner (Retired)				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) New York			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Patrick O'HARA						14 MOTHER'S MAIDEN NAME Mary MAHER					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16 SOCIAL SECURITY NO. WWI		17 INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE COR PULMONALE 527.1 DUE TO PULMONARY EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										INTERVAL BETWEEN ONSET AND DEATH 2 DAYS YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)			
21 I certify that (X) (this hospital) attended the deceased from Dec. 3 19 60 to Dec. 6 19 60 that (X) (we) last saw the deceased alive on Dec. 6 19 60 , and that death occurred at 6:35AM from the causes and on the date stated above											
22a. SIGNATURE Russell Miller, Jr. MD						M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-6-60			
22c. PHYSICIAN'S NAME (Type) Russell MILLER, LT, MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) (State) Arlington Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros						ADDRESS Simmons Bros., 1661 Good Hope Rd., SE, WashDC		25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

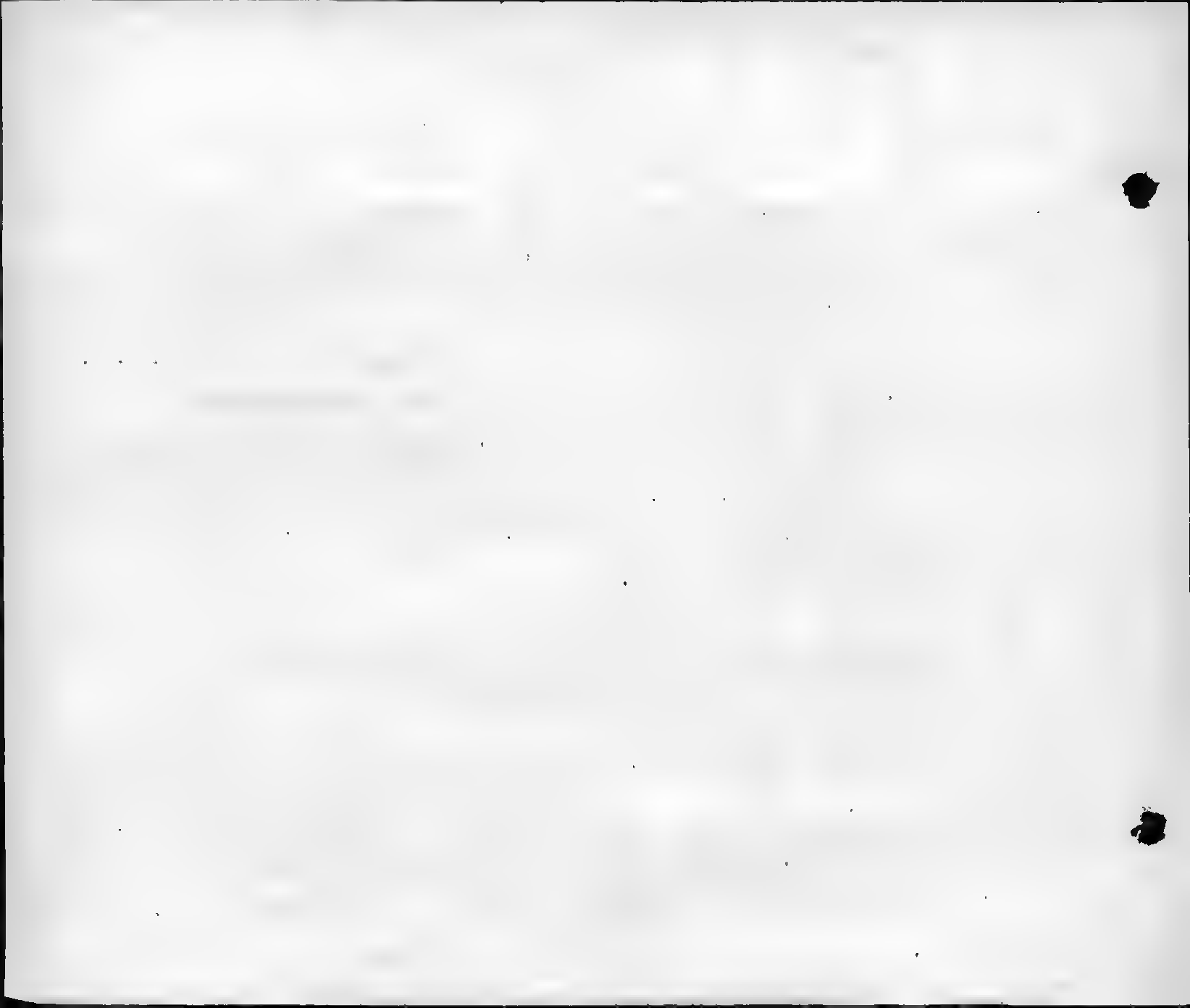
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14177

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14127

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c LENGTH OF STAY IN 1b 2 DAYS			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKEVILLE, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CURTIS Middle BLAIR Last O'KEEFE				4. DATE OF DEATH Month 12 Day 7 Year 19 60			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/60		9. AGE (in years last birthday) yrs 2	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min 2	IF UNDER 24 HRS Hours 2 Min 2
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME DONALD GRANVILLE O'KEEFE				14. MOTHER'S MAIDEN NAME SALLY KATHLEEN SIMONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis of lungs, bilateral Conditions, if any which gave rise to immediate cause (a), stating the underlying cause (b) AND BRONCHO PNEUMONIA, BILATERAL DUE TO (c) ASPIRATION OF AMNIOTIC FLUID INTERVAL BETWEEN ONSET AND DEATH 2 days 1 DAY 2 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 12/5/60 to 12/7/60 that (I) last saw the deceased alive on 12/7/60 , and that death occurred 4:30 M, from the causes and on the date stated above							
22a. SIGNATURE Charles S. Whitaker				M D ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/8/60	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.				22d. ADDRESS CLARKSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Dec 9-60		23c. NAME OF CEMETERY OR CREMATORY St James Cemetery		23d. LOCATION (City, town or county, (State) Clarksville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James J. [Signature]				ADDRESS James J. [Signature]		25a. REC'D BY REGISTRAR DATE DEC 14 '60	
						25b. REGISTRAR'S SIGNATURE Charles S. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

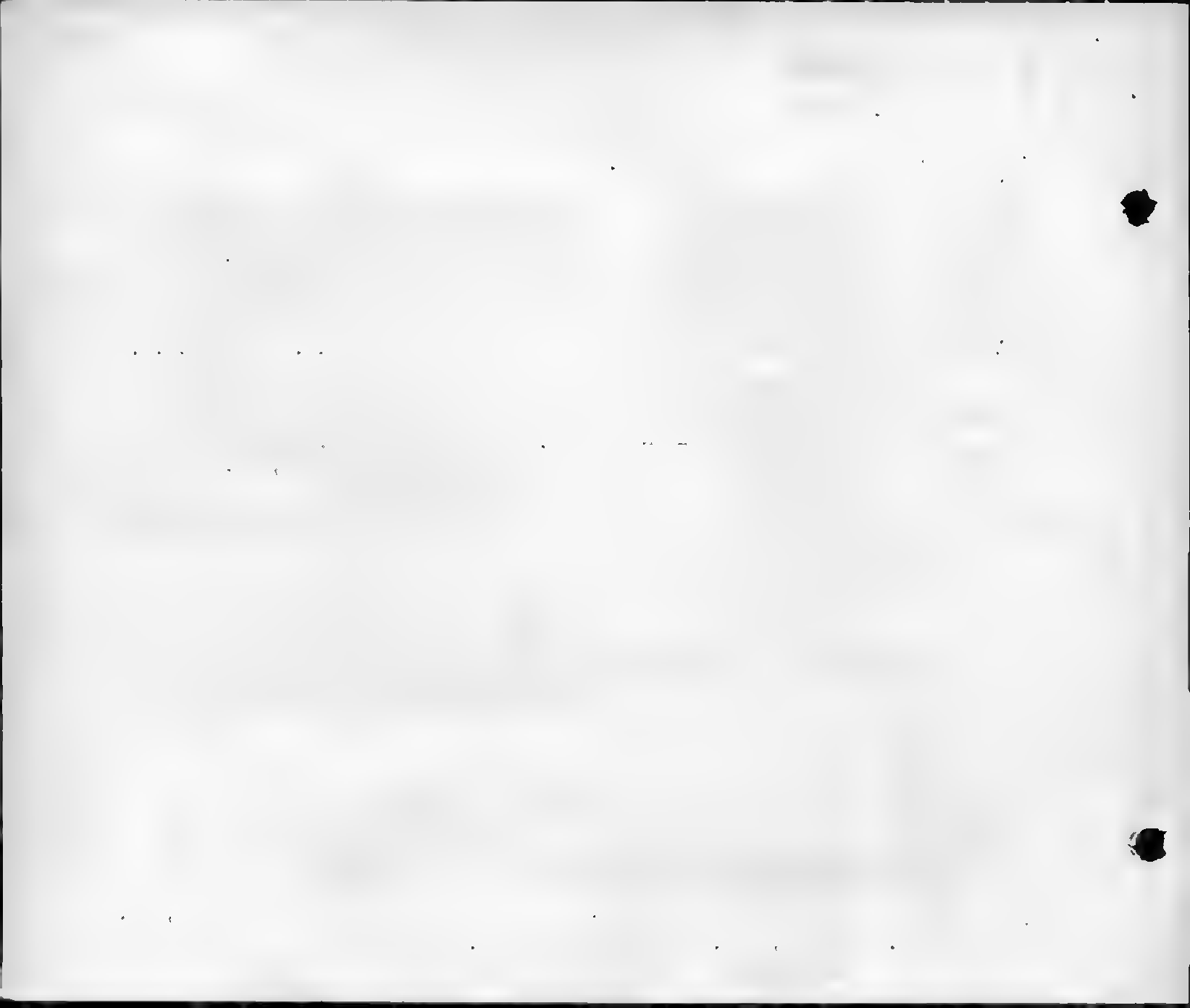
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14082

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE c. LENGTH OF STAY IN 1b 4 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4610 WILWYN WAY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 4610 WILWYN WAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) First CATHERINE Middle MAY Last ORPHANOS		4. DATE OF DEATH Month DEC. Day 27 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/08
9. AGE (In years, last birthday) 52 yrs		10. KIND OF BUSINESS OR INDUSTRY FLORIST	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORAL ARRANGER		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME JOHN ROBERT BYRON		15. MOTHER'S MAIDEN NAME KATHERINE BOWERS TURNER	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO 579-14-3265	
18. INFORMANT Mr. Achilles Orphanos, 4610 Wilwyn Way, Rockville, Md.		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Arterio-sclerosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last Arterial Hypertension (b) Undetermined (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis old, multiple. INTERVAL BETWEEN ONSET AND DEATH 1 hour			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 10 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1, 1957 to Dec 27, 1960 that (I) (we) last saw the deceased alive on Nov 26, 1960 and that death occurred at 4 PM from the causes and on the date stated above			
22a. SIGNATURE George L Ball		22b. DATE SIGNED Dec 27, 1960	
22c. PHYSICIAN'S NAME (Type) George L Ball		22d. ADDRESS 10670 Georgia Ave Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/30/60	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PIMPHREY, INC. Raymond A. Fisher		25a. REGISTRY REGISTRAR JAN 3 1961 DATE	
25b. REGISTRAR'S SIGNATURE Robert L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death—Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner, Montgomery County, D. Brochart informed concerning circumstances and he authorized me to sign this certificate.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FURNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14129

14178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs</u>		d. STREET ADDRESS <u>507.5 Bradley Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>507.5 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Barbara Elizabeth Ostroski</u>	4. DATE OF DEATH <u>Dec 29</u> 19 <u>60</u>	5. AGE (In years last birthday) <u>32</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cal.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cal.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. L. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Kara Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>John Ostroski</u> Address <u>Dec 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central hemorrhage & laceration</u> DUE TO (b) <u>Bullet wound in skull (rt.)</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted bullet wound in skull</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year <u>12-29-1960</u> Hour <u>2</u> p.m.		20d. INJURY OCCURRED <u>at work</u> <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 30 60</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14179

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14130

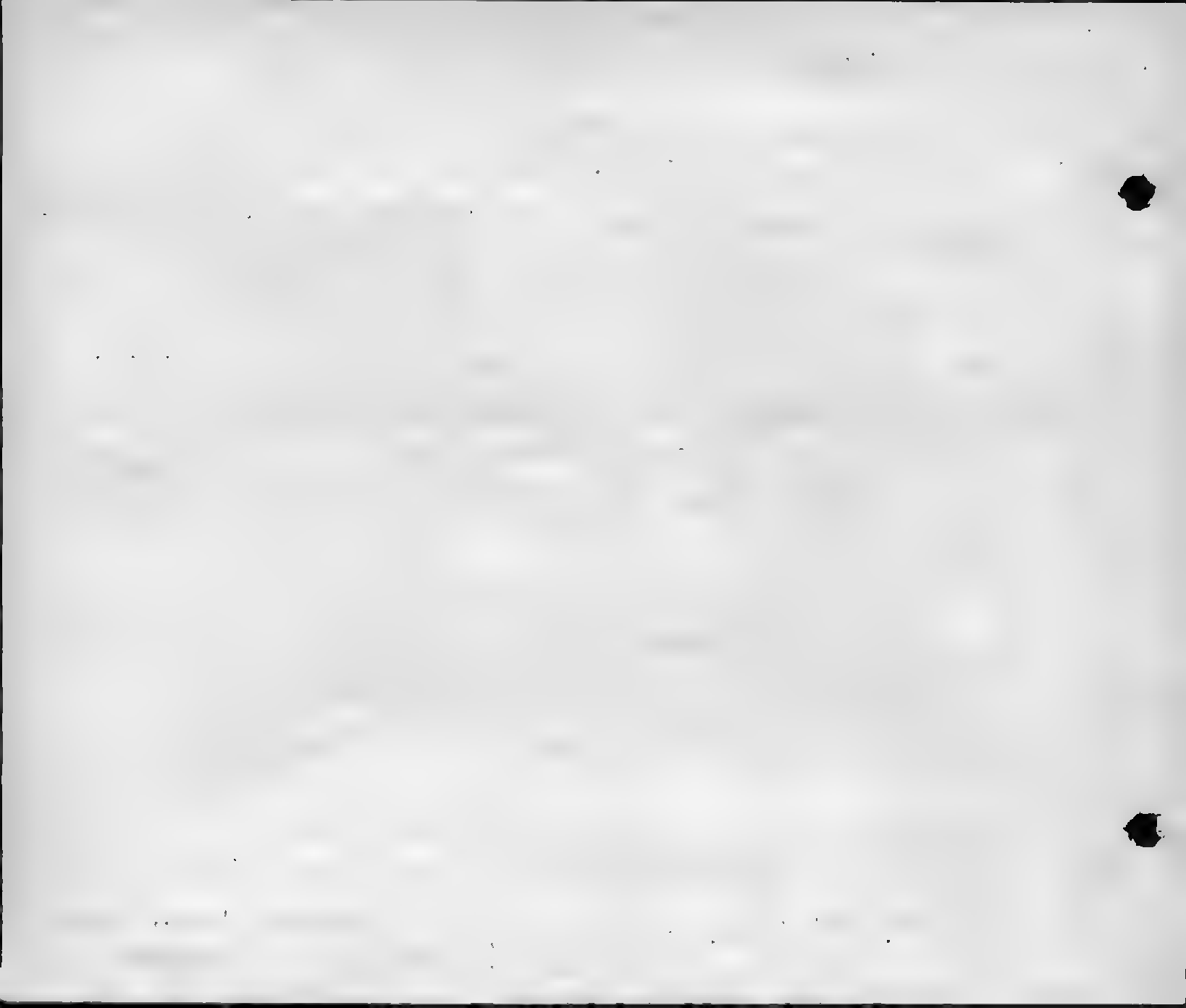
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>11602 Georgia St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Paper</u> Last <u>Paper</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 23, 1913</u>	9. AGE (In years last birthday) <u>37 yrs</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Gortler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>351-14-1984</u>		17. INFORMANT <u>Hyman Paper</u> (Brother)		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>Subarachnoid Hemorrhage</u> <u>Spontaneous</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture cerebral blood vessel</u> DUE TO <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>28 Hrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-5-60</u> , 19 <u> </u> , to <u>12-6-60</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12-6</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above							
22a. SIGNATURE <u>Morris Perry</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602 Georgia Avenue SSpG, Md.</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gooding Funeral Home #217-9 St. Ned.</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>				25c. REGISTRAR'S SIGNATURE <u> </u>			



13 1
FOR STATE HEALTH DEPT. (M)
X
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14015
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11131

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>12 yrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10215 Woodmont Circle</u>				d. STREET ADDRESS <u>10215 Woodmont Circle</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Perego</u>		4. DATE OF DEATH <u>Dec 5 1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-91</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Perego</u>		14. MOTHER'S MAIDEN NAME <u>Louise Oakley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-12-2949</u>		17. INFORMANT <u>Elva Perego</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Acute Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>434.1</u> DUE TO <u>Acute Congestive Heart Failure</u> (a), stating the underlying cause last. (c) <u>434.1</u> DUE TO <u>Acute Congestive Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolism</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLASZCZAK</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>DEC. 8, 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>				22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGE'S CO. MARYLAND</u>			
23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC. 8434 GEORGIA AVE., SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>				24c. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14132

14180

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7700 Old Chester Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Bethesda	
		d. STREET ADDRESS 7700 Old Chester Rd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE Middle KIMBALL Last PETERSON		4. DATE OF DEATH Month Dec. Day 9, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1877
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 4 Days 14	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Roxbury, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arba D. Kimball		14. MOTHER'S MAIDEN NAME Julia Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sister		Address Mrs. Bess K. Kicklighter Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 6 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1958 to 9 Dec , 19 60 , that I last saw the deceased alive on 28 Nov , 19 60 , and that death occurred at 5-29 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5029 Bethesda (w) DATE SIGNED 9 Dec 60			
ACTUAL SIGNATURE Herbert Martin M.D. 5029 Bethesda (w)			
PHYSICIAN'S NAME (Type) HERBERT MARTIN JR Bethesda, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	22b. DATE THEREOF 12-11-60	22c. NAME OF CEMETERY OR CREMATORY Patton's Cemetery	22d. LOCATION (City, town, or county) (State) LaPorte, Indiana
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DEC 15 1960	24b. REGISTRAR'S SIGNATURE C. L. S. H. H. H.

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

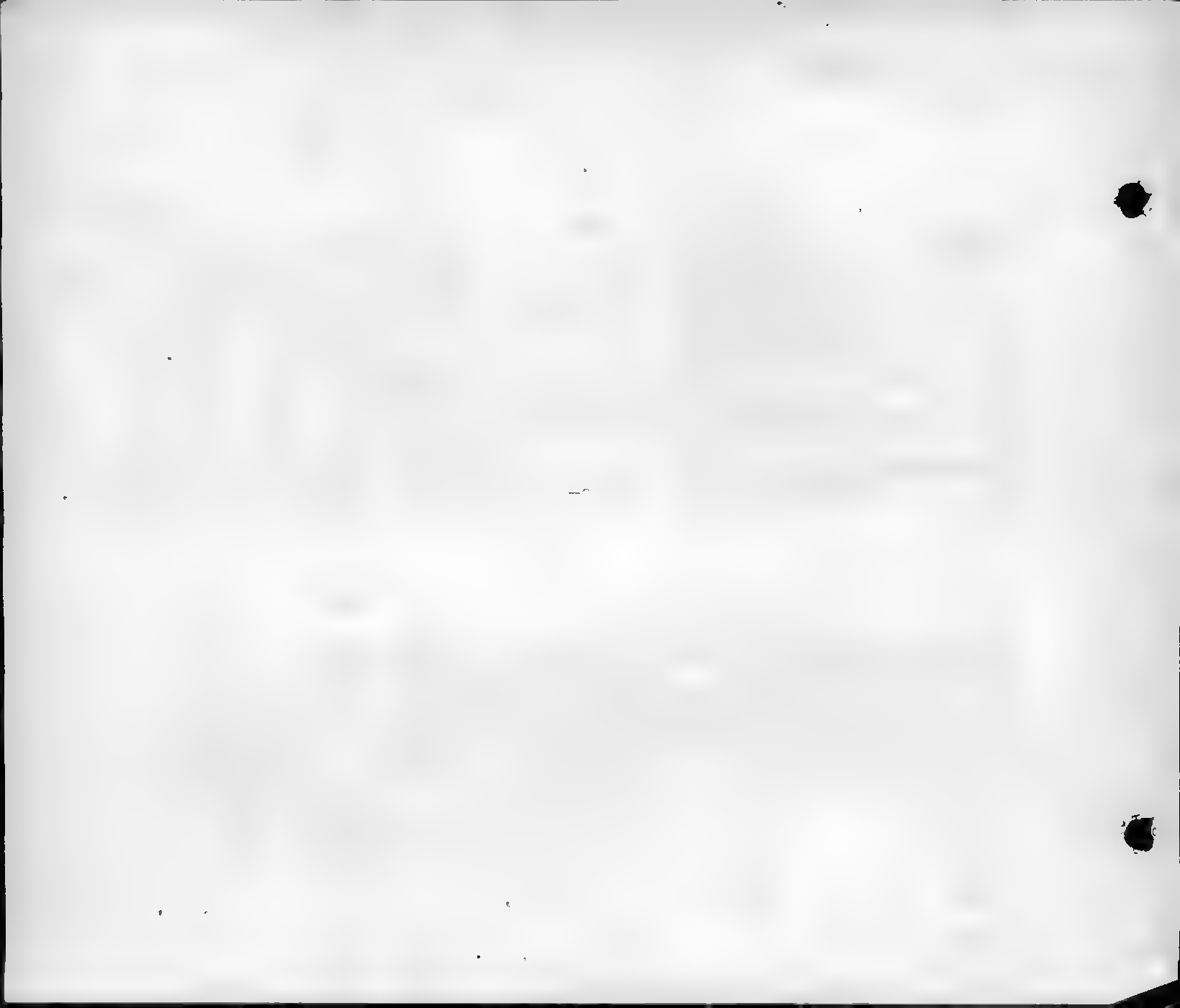
Reg. Dist. No.

14133

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>14 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>1 Route 3</u>	
3. NAME OF DECEASED (Type or print) <u>Ronald L Phillips</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1958</u>
9. AGE (In years last birthday) <u>2 yrs</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u>	
11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co. Md.</u>	
13. FATHER'S NAME <u>Houston Prather</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>1-11-111111</u>	
17. INFORMANT <u>Eliza Phillips</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>			
491X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u>			
(c) <u>Due to</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosnart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosnart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE WHEREOF <u>12/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		22d. LOCATED ON (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. J. K. K.</u>	



14182

CERTIFICATE OF DEATH

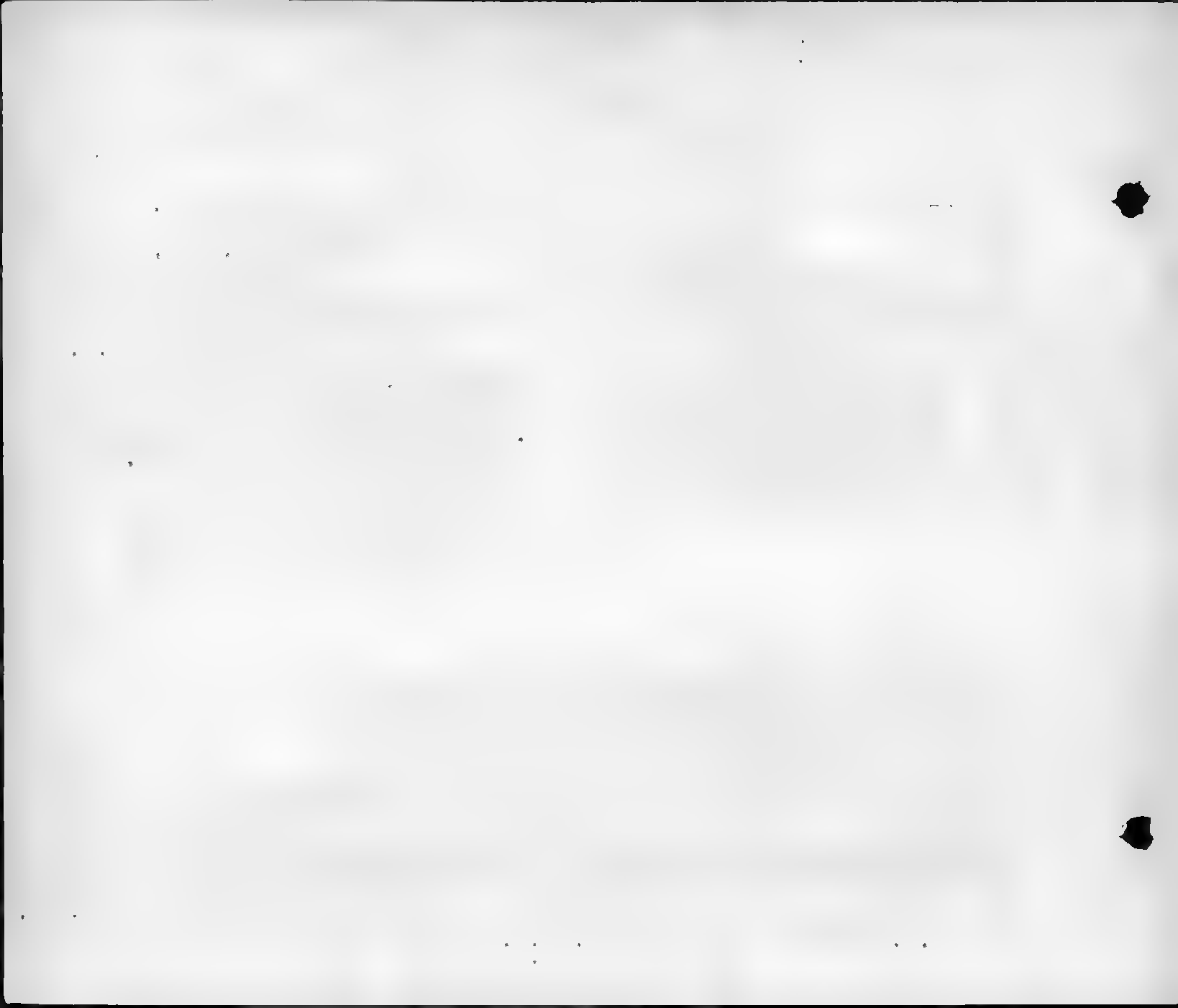
14134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fulton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Rest Home				d. STREET ADDRESS 804 Butternut Street, N.W.			
3. NAME OF DECEASED (Type or print) First Agnese Middle Pieri Last Pieri				4. DATE OF DEATH Month Dec. Day 6, Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/1879	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 5 Days 3 Hours 0 Min. 0	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adriano Giannini				14. MOTHER'S MAIDEN NAME Semira ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO no		17. INFORMANT Mrs. Semira M. Ford--9711 Holmhurst Road Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) CORONARY THROMBOSIS DUE TO (c) 3 days				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS; CEREBRAL ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 2 , 1960, to Dec 6 , 1960, that I last saw the deceased alive on Dec 6 , 1960, and that death occurred at 6:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D.							
PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D., CLARKSVILLE, MD. 12/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/9/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum Prince Georges County, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any changes necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

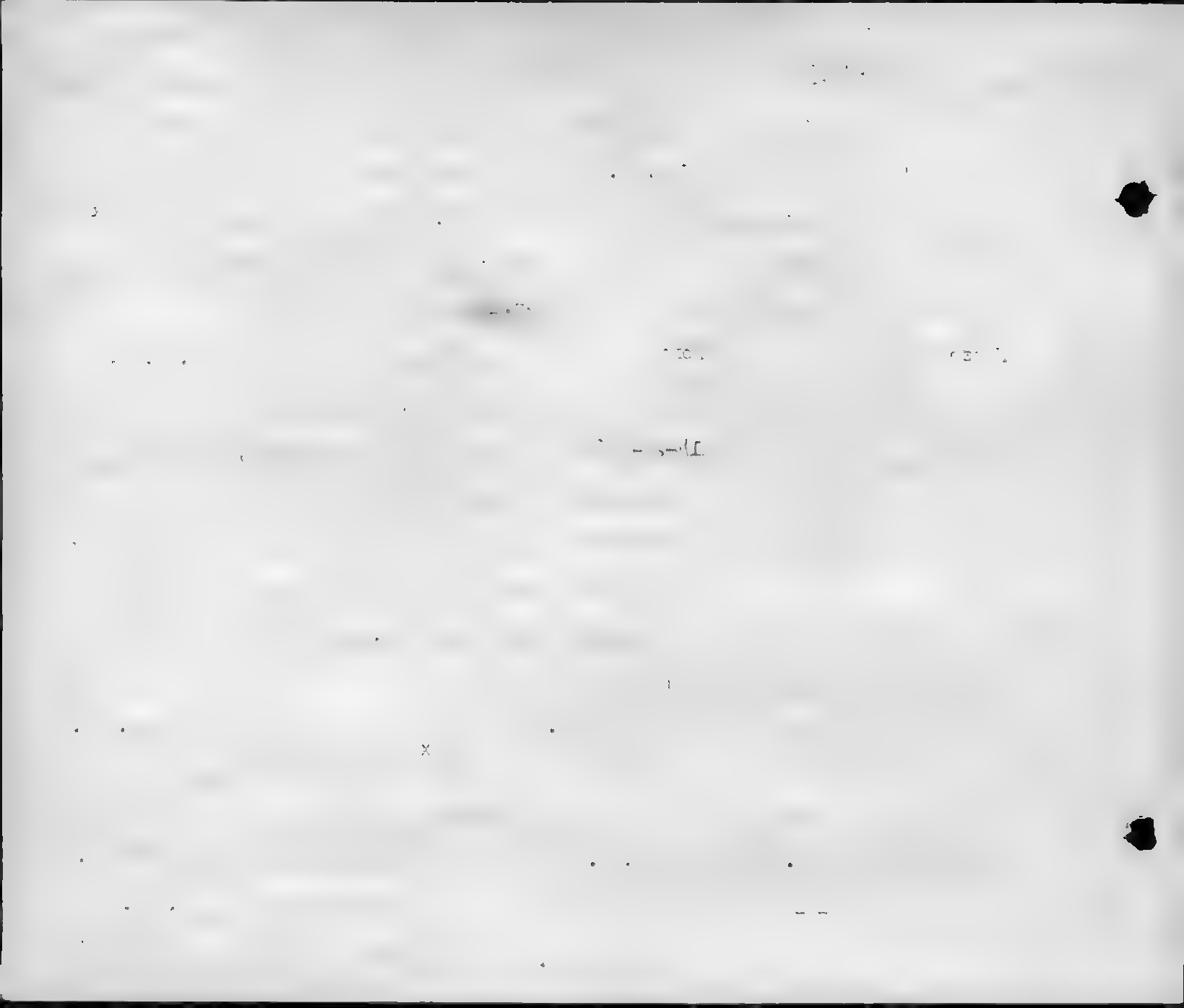
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14183

14135

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN IL 19 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS GAITHERSBURG	
3. NAME OF DECEASED (Type or print) CORA		4. DATE OF DEATH DECEMBER 6 19 60	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan 1, 1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME FLOYD RAY		14. MOTHER'S MAIDEN NAME CELIA CUMPTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 21-24-2268	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE Conditions, if any, which gave rise to immediate cause (b) FRACTURE OF SKULL (a), stating the underlying cause last (c) STRUCK BY AUTO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): COMPOUND FRACTURE OF RIGHT LEG - FRACTURE 3RD RIB, RIGHT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) PEDESTRIAN STRUCK BY AUTOMOBILE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:25 12/5/60 p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MD. R 115		20f. (City or town) (County) (State) GAITHERSBURG, MONTG. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 18 1/2 HRS.	
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-60	
22c. NAME OF CEMETERY OR CREMATORY Flower Hill		22d. LOCATION (City, town, or country) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR Louis H. Barber		24a. REC'D BY REGISTRAR DEC 9 '60	
ADDRESS Laytonville, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

MEDICAL CERTIFICATION



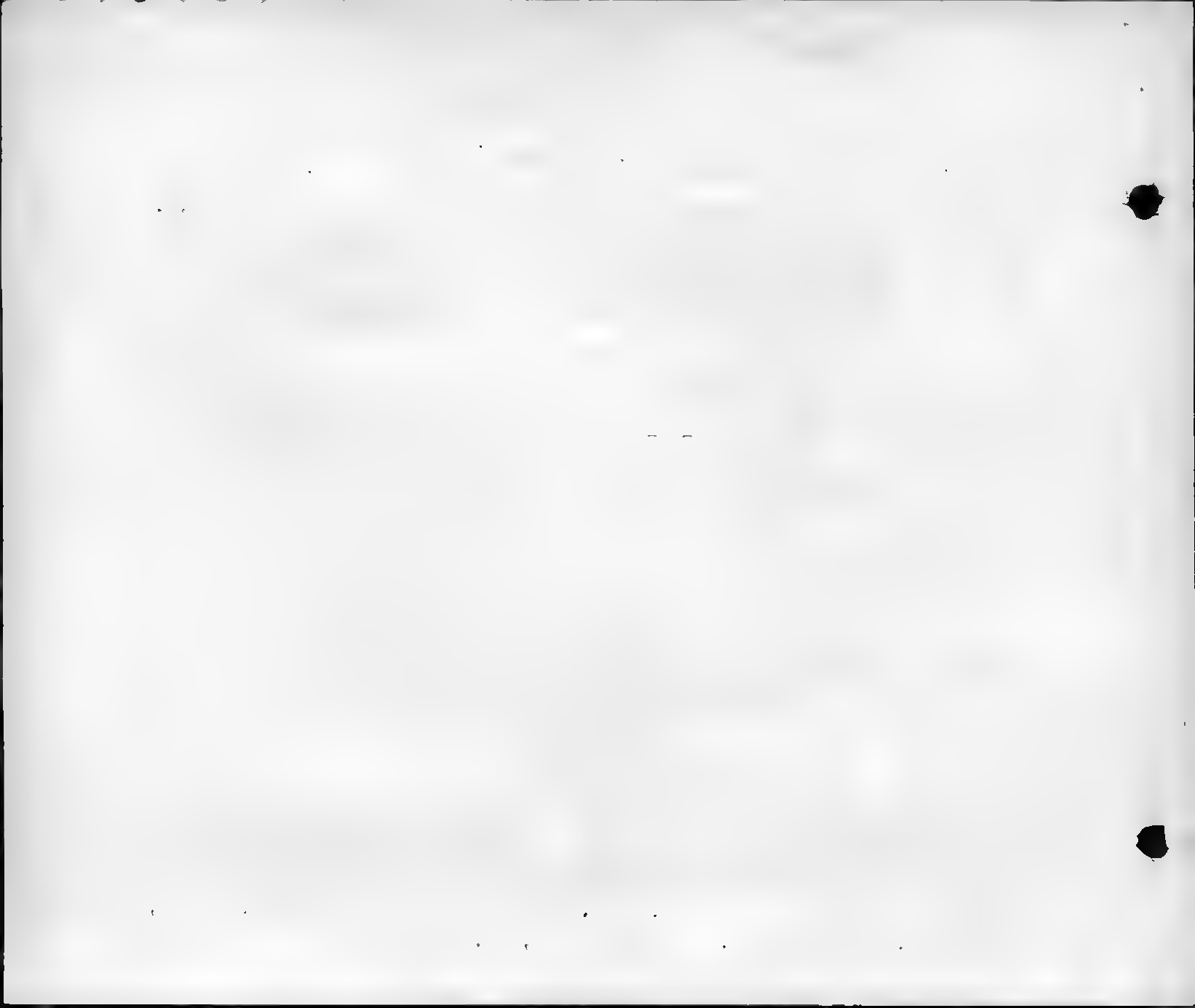
14050

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14136

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Silver Spring</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>555 University Blvd., E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Ollie Blanche Printz</u>				4. DATE OF DEATH Month Day Year <u>Dec. 2 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-93</u>	9. AGE (In years last birthday) <u>67 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. SOMERS</u>				14. MOTHER'S MAIDEN NAME <u>Artie Seal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-28-4586</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Dilatation Commao duct secondary to fibrosis Sphincter Oddi</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 7th</u> 19 <u>60</u> , to <u>Dec 2nd</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec 2nd</u> 19 <u>60</u> , and that death occurred at <u>3:30</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Lyle Williams</u> M.D.				22b. DATE <u>Dec 2nd 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lyle Williams M.D.</u>				22d. ADDRESS <u>7717 Garland Ave, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. PIMPLEY, INC.</u> <u>Raymond A. Ziska</u>				25a. REC'D BY REGISTRAR <u>DEC 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

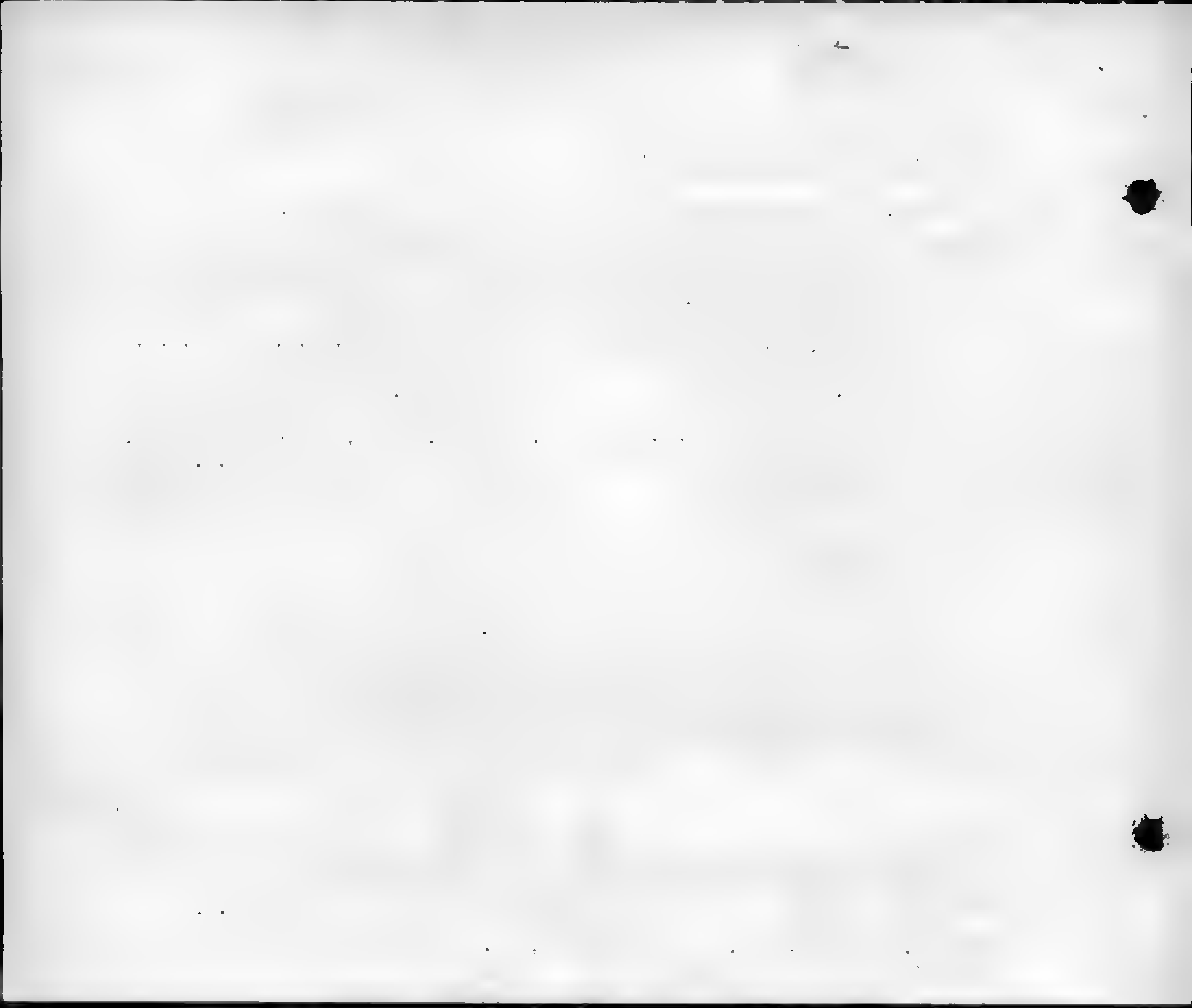
VR A15 (4)
15M 9/59

14051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14137

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OAKHAVEN CONVELESCENT HOME		d. STREET ADDRESS 1673 PARK ROAD, NW.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Maries NELSON N. PUMPHREY		4. DATE OF DEATH Month Day Year DECEMBER 26 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IFM Operator		10b. KIND OF BUSINESS OR INDUSTRY Dupont Laundry	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES B. PUMPHREY		14. MOTHER'S MAIDEN NAME MOLLIE H. PLUMMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-01-6316	
17. INFORMANT Mrs. James G. Berry, 637 Longfellow St.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
21. I certify that (I) (this hospital) attended the deceased from 11/20/1960 to 12/26/1960 that (I) (we) lost the deceased alive on 12/22/1960 and that death occurred on 12/26/1960 from the causes and on the date stated above.		22a SIGNATURE Chas H Wolohin, M.D. 22b DATE SIGNED 12/26/60	
22c PHYSICIAN'S NAME (Type) Chas H Wolohin		22d. ADDRESS 7401 BLair Rd NW	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 12/28/60	
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Glyndon U. Ziska		25a REC'D BY REGISTRAR DATE JAN 3 6.	
25b REGISTRAR'S SIGNATURE John S. Thomas			



14074

CERTIFICATE OF DEATH

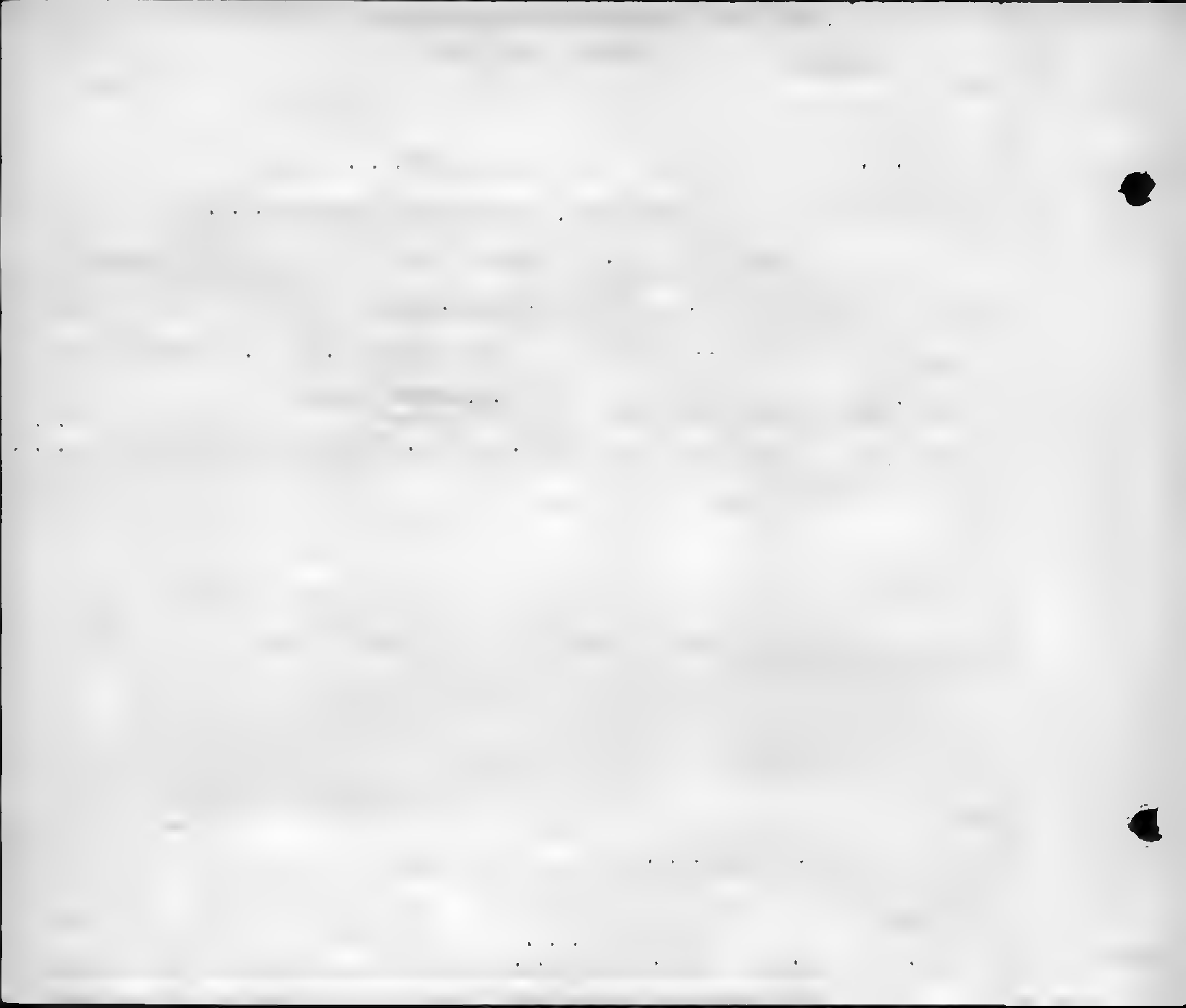
Reg. Dist. No.

14138

1. PLACE OF DEATH o. COUNTY MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM 5000 MCCOMAS.		d. STREET ADDRESS 7705-MORNINGSIDE DRIVE, N.W.	
3. NAME OF DECEASED (Type or print) First EVA Middle M. Last RAUCHENSTEIN		4. DATE OF DEATH Month DECEMBER Day 25th Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. AGE (In years last birthday) 84 yrs.	
10a. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) WASHINGTON, DIST. OF COL.	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME SAMUEL E. SHIELDS	
14. MOTHER'S MAIDEN NAME JOSEPHINE Shields		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT (Daughter) MRS. JAMES H. REES 7705-MORNINGSIDE DRIVE, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary infarction DUE TO (c) Thrombosis left femoral vein		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 wks. 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1960 , to December 24, 1960 , that I last saw the deceased alive on Dec 23, 1960 , and that death occurred at 1:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Coleman MD		ADDRESS (Street, city or town, state) 733 Sligo Ave. Silver Spring Maryland	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN, M.D.		DATE SIGNED Dec. 25, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 28, 1960	22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEM.	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOYNG CO.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14184
14139
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>3 hr.</u>				d. STREET ADDRESS <u>4520 Rosedale Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Reichard</u>			4. DATE OF DEATH <u>Dec. 14, 1960</u>			19 <u>19</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 12, 1870</u>	
9. AGE (in years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Sellers</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Markley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Evelyn Burrows</u> Address <u>4616 Chesapeake St. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>450.0</u> DUE TO <u>Myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis generalized</u> (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 1954</u> to <u>12-14, 1960</u> , that (2) (we) last saw the deceased alive on <u>12-14, 1960</u> , and that death occurred at <u>3:15</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Alfred S. Norton</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>				22d. ADDRESS <u>4711 Highland Ave. Bethesda, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John Reformed Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Northampton Co. Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REG STRAR DATE <u>DEC 20 '60</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. 8 Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14052

14140

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY (If not in hospital, give street address)

28 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hospital

3. NAME OF DECEASED

(Type or print)

Irene

First

Middle

NMN

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED

8. DATE OF BIRTH

January 1, 1914

9. AGE (In years last birthday)

46 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Samuel Ruback

14. MOTHER'S MAIDEN NAME

Bessie Katz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Address

Washington Sanitarium & Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Carcinoma of Brain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

Carcinoma of Lung

INTERVAL BETWEEN ONSET AND DEATH

1 month

5 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3 Aug 1960 to 23 Dec 1960 that (II) (we) last saw the deceased alive on 22 Dec 1960, and that death occurred at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE

Thomas P Fogarty

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

23 Dec 1960

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

1011 Univ. Blvd E Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12-23-60

23c. NAME OF CEMETERY OR CREMATORY

Beth T Fildes

23d. LOCATION (City, town or county)

Balto

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

Jack Lowrie 2100 Cedar Lane.

25a. REC'D BY REGISTRAR

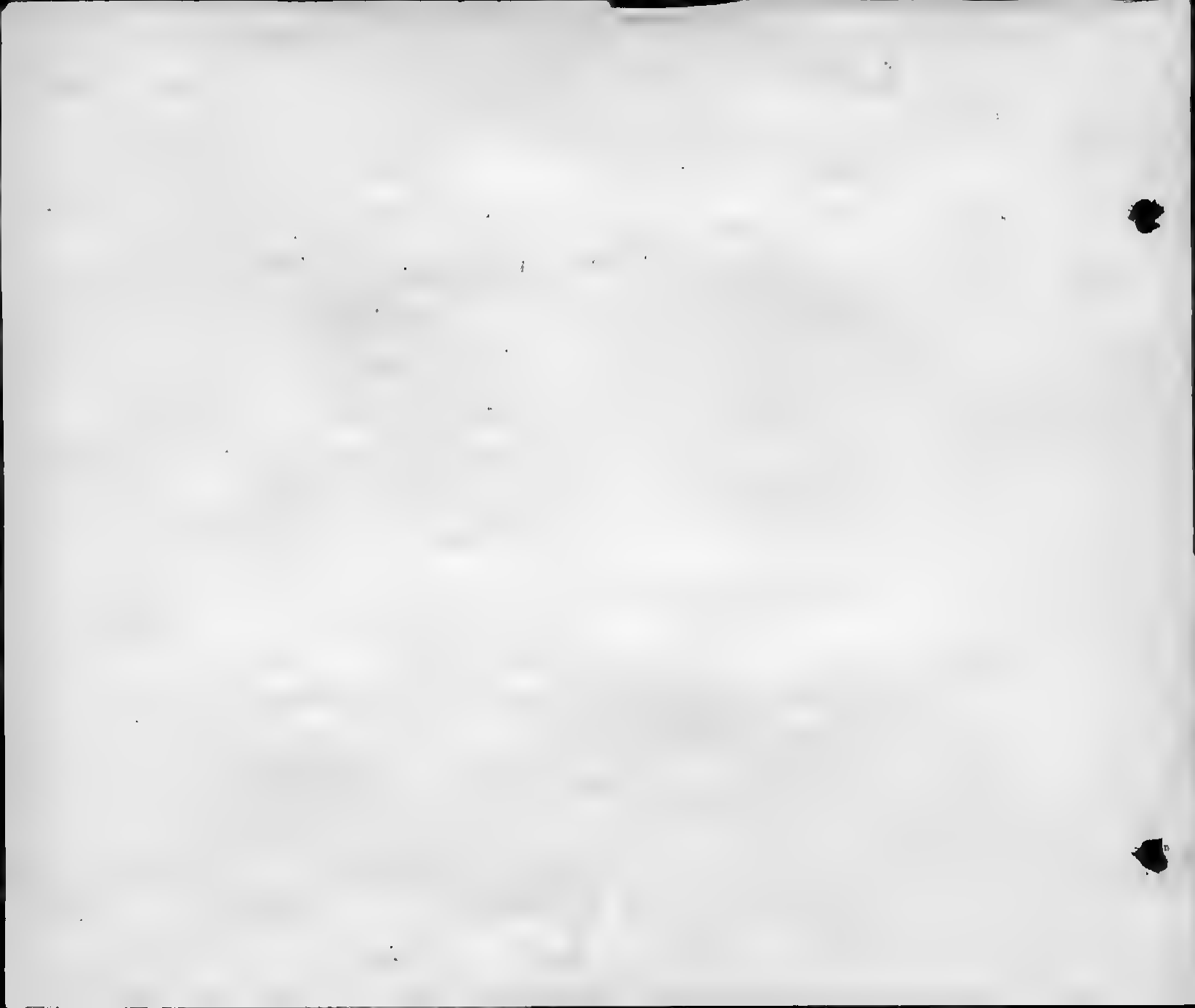
DEC 27 '60

25b. REGISTRAR'S SIGNATURE

Charles E. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (4)
15M 9/60



14185

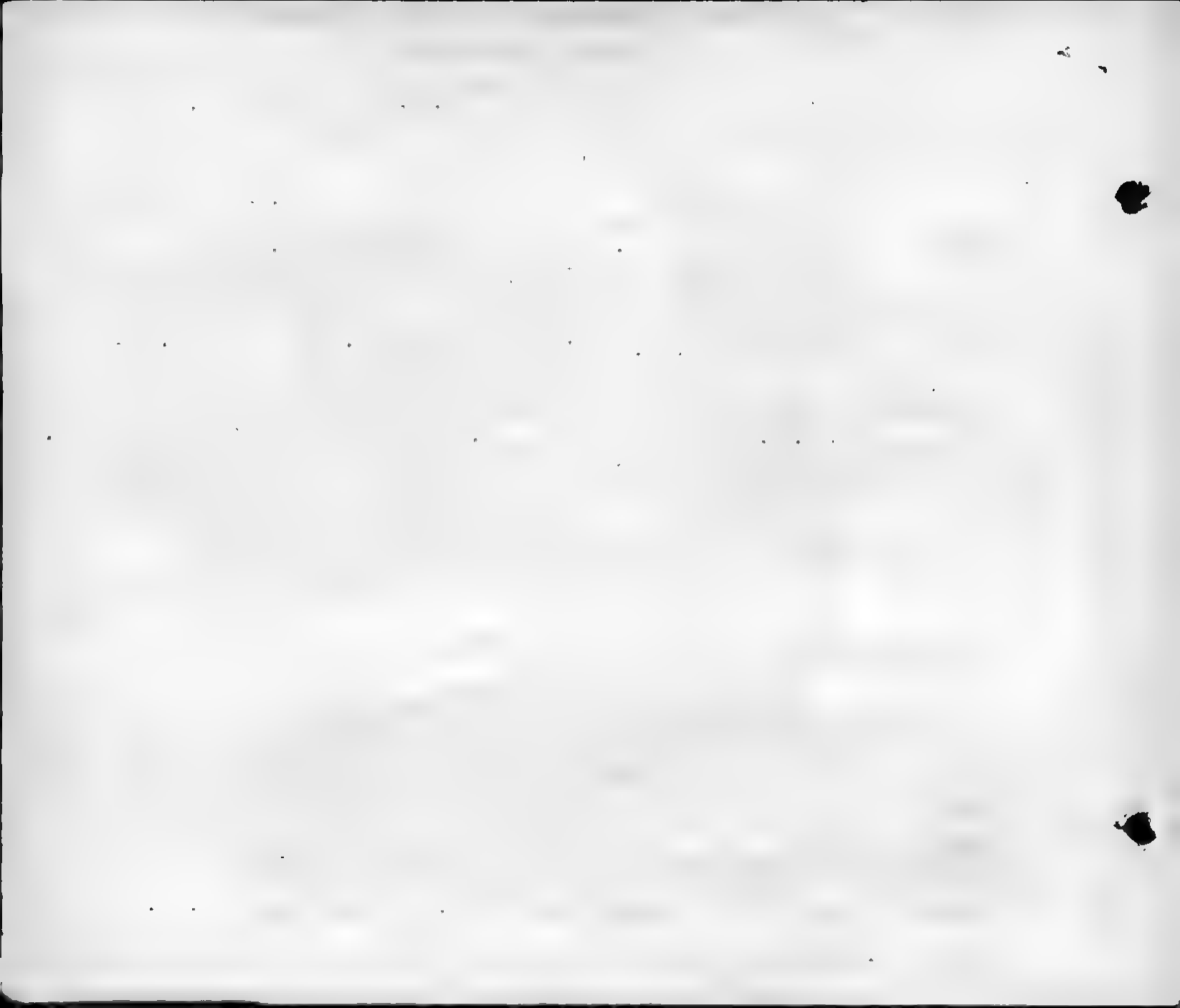
CERTIFICATE OF DEATH

Reg. Dist. No. 14141

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 14 hours			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month Dec. Day 7 Year 1960			
3. NAME OF DECEASED (Type or print) First Eber Middle F. Last Riley				5. SEX Male			
6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/10		9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Rate Specialist		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry F. Riley				14. MOTHER'S MAIDEN NAME Emma Eber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 577-32-6783		17. INFORMANT Harry C. Riley (brother) Address Bethesda 6622 Braeburn Pkwy./			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombosis left coronary artery DUE TO 3 day (c) Arteriosclerosis DUE TO 3 day				INTERVAL BETWEEN ONSET AND DEATH 3 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Excess fat				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1960 to 11-7 , 19 60 , that I last saw the deceased alive on 11-7 , 19 60 , and that death occurred at 11:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4241 Fessenden DATE SIGNED 12-7-60							
ACTUAL SIGNATURE P.P. Andrews M.D.				PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D. Washington 16 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/60		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE DEC 9 '60		24b. REGISTRAR'S SIGNATURE S. S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14186

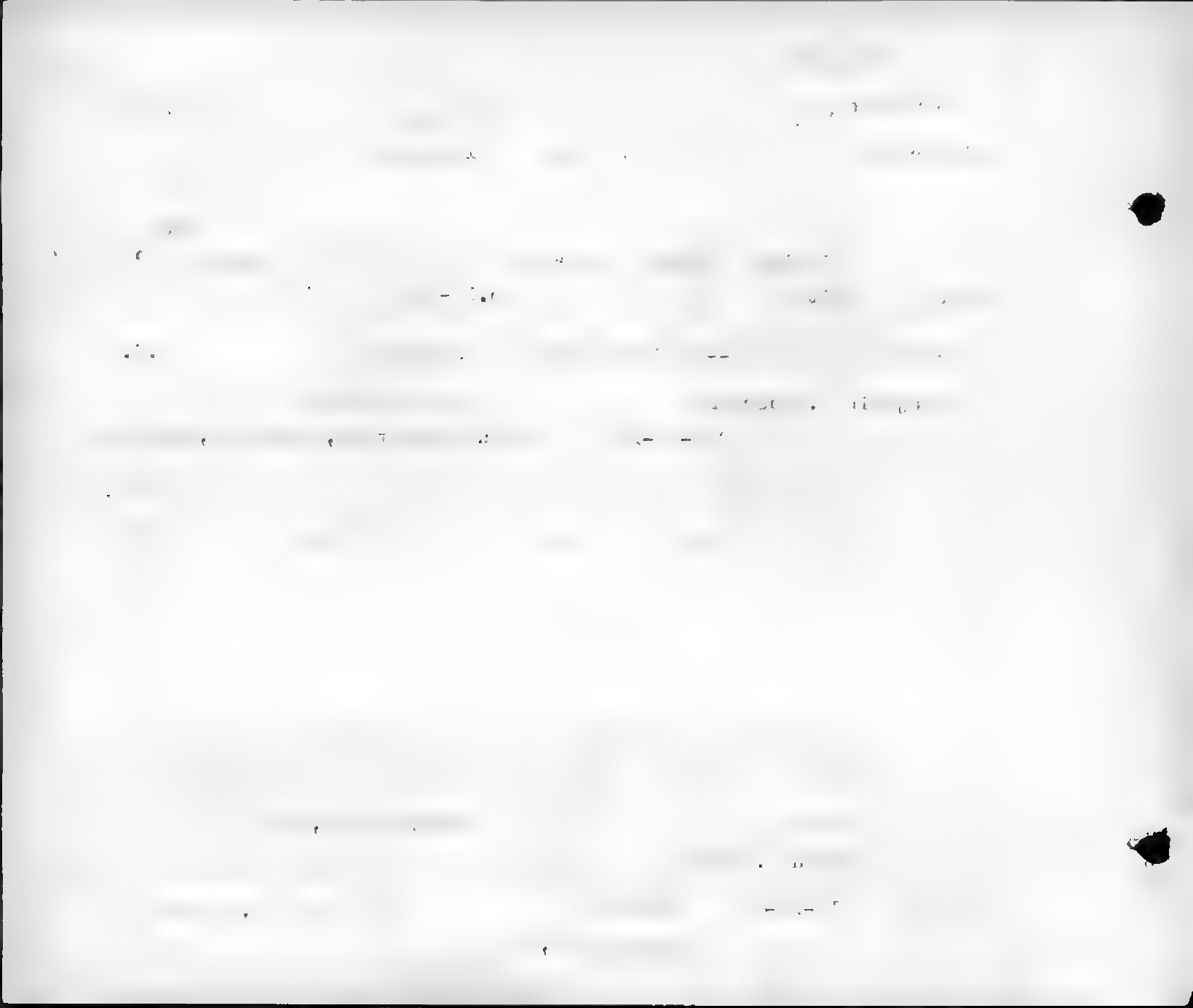
CERTIFICATE OF DEATH

Reg. Dist. No. 14142

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. an. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b 76 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Edgar Last Roberson		4. DATE OF DEATH Month 26 Day 26 Year 1960 December 26, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14-1884
9. AGE (In years birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor--Self employed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin F. Roberson		14. MOTHER'S MAIDEN NAME Mollie Purdy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-2777	
17. INFORMANT Mrs Ruth Roberson, Dickerson, Maryland		Address	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukemia, Chronic Myelogenous DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 days 4 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe Gouty Arthritis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Oct., 1960 , to 26 Dec., 1960 , that I last saw the deceased alive on 24 Dec., 1960 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED			
ACTUAL SIGNATURE Gordon M. Smith		M.D. Barnesville, Md	
PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF 12-29-60	22c. NAME OF CEMETERY OR CREMATORY Monocacy	22d. LOCATION (City, town, or county) (State) Beallsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton		ADDRESS Barnesville, Md	
24a. REC'D BY REGISTRAR DATE DEC 30 '60		24b. REGISTRAR'S SIGNATURE W. B. Helton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

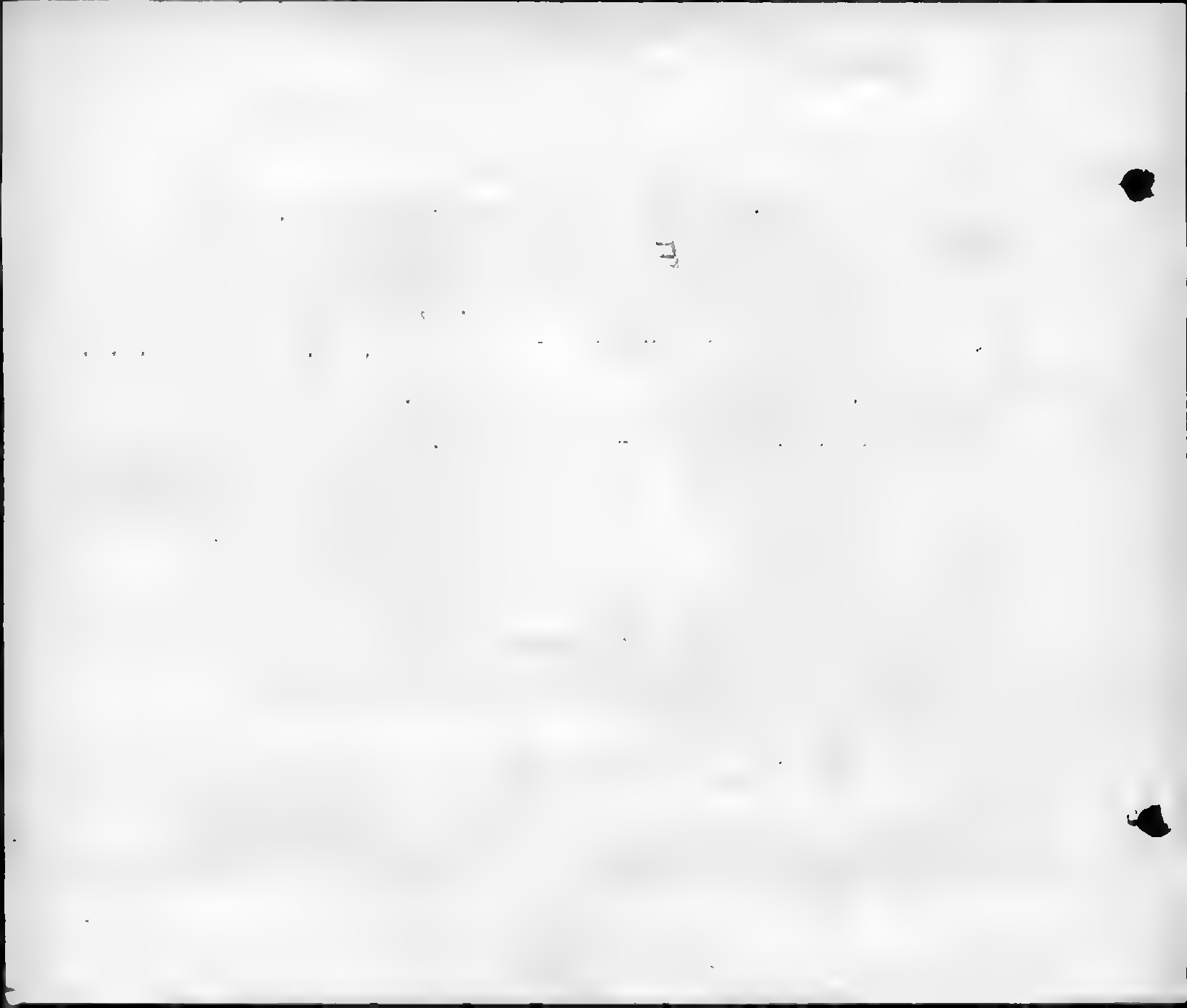
14187

14143

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6004 Highland Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>F</u> Last <u>Robynette</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>YY</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1884</u>		9. AGE (in years last birthday) <u>76</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William G. Firoved</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Shuffler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>- - - -</u>		17. INFORMANT <u>Sadie F. Hughes</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>SIX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt. Femur, surgical neck Sept. 10, 1960</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 27, 1960</u> to <u>Dec 3, 1960</u> that (I) (we) last saw the deceased alive on <u>Nov 26, 1960</u> and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank S. Bacon</u>				22b. ADDRESS <u>1150 - Conn. Ave. N.W. Washington DC</u>		22c. DATE SIGNED <u>DEC 6 '60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Suitland</u>				23e. (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Hawley's Sons Inc.</u>				ADDRESS <u>Wash. 6, DC</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 21 Form 278 1-1

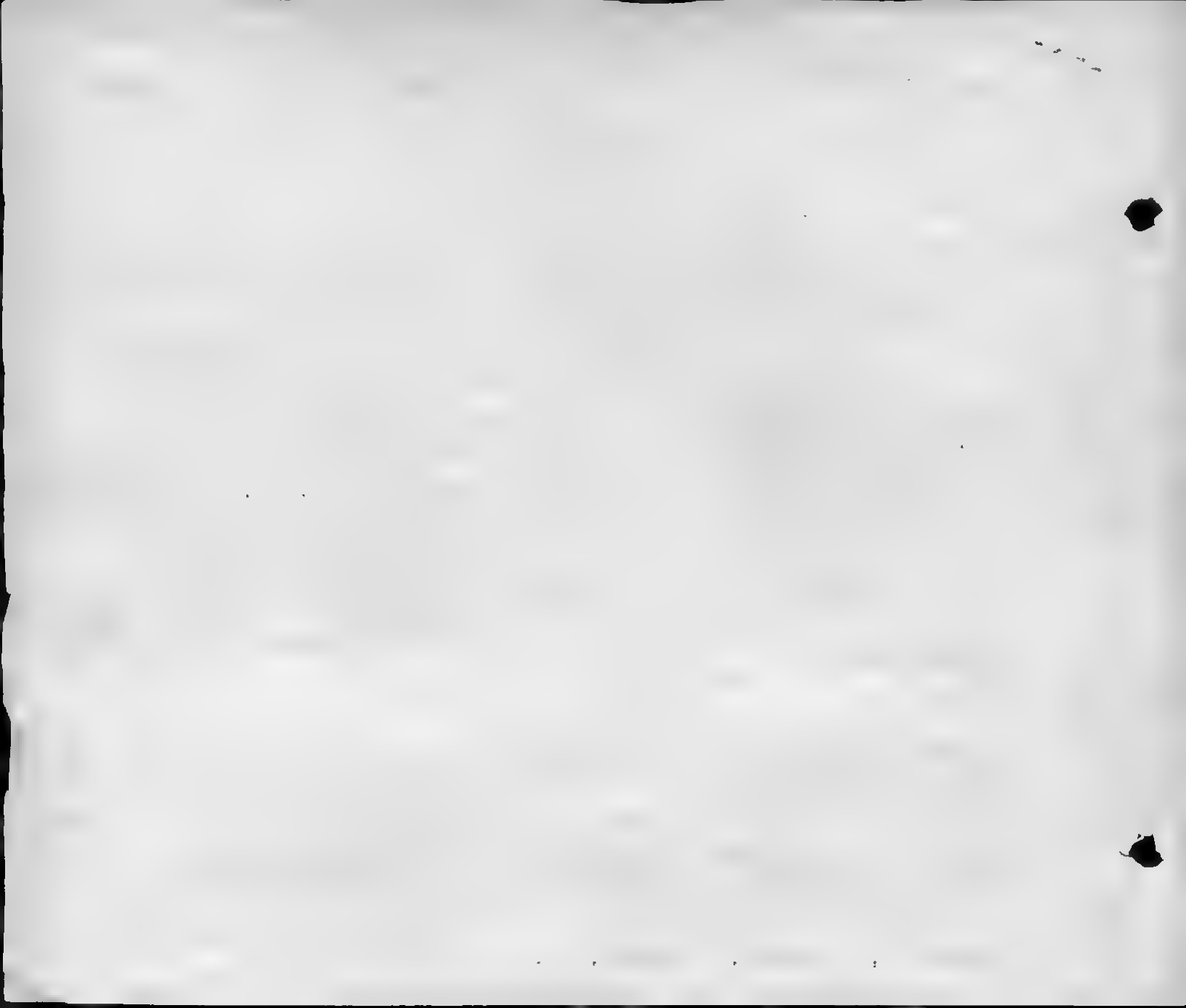
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14188

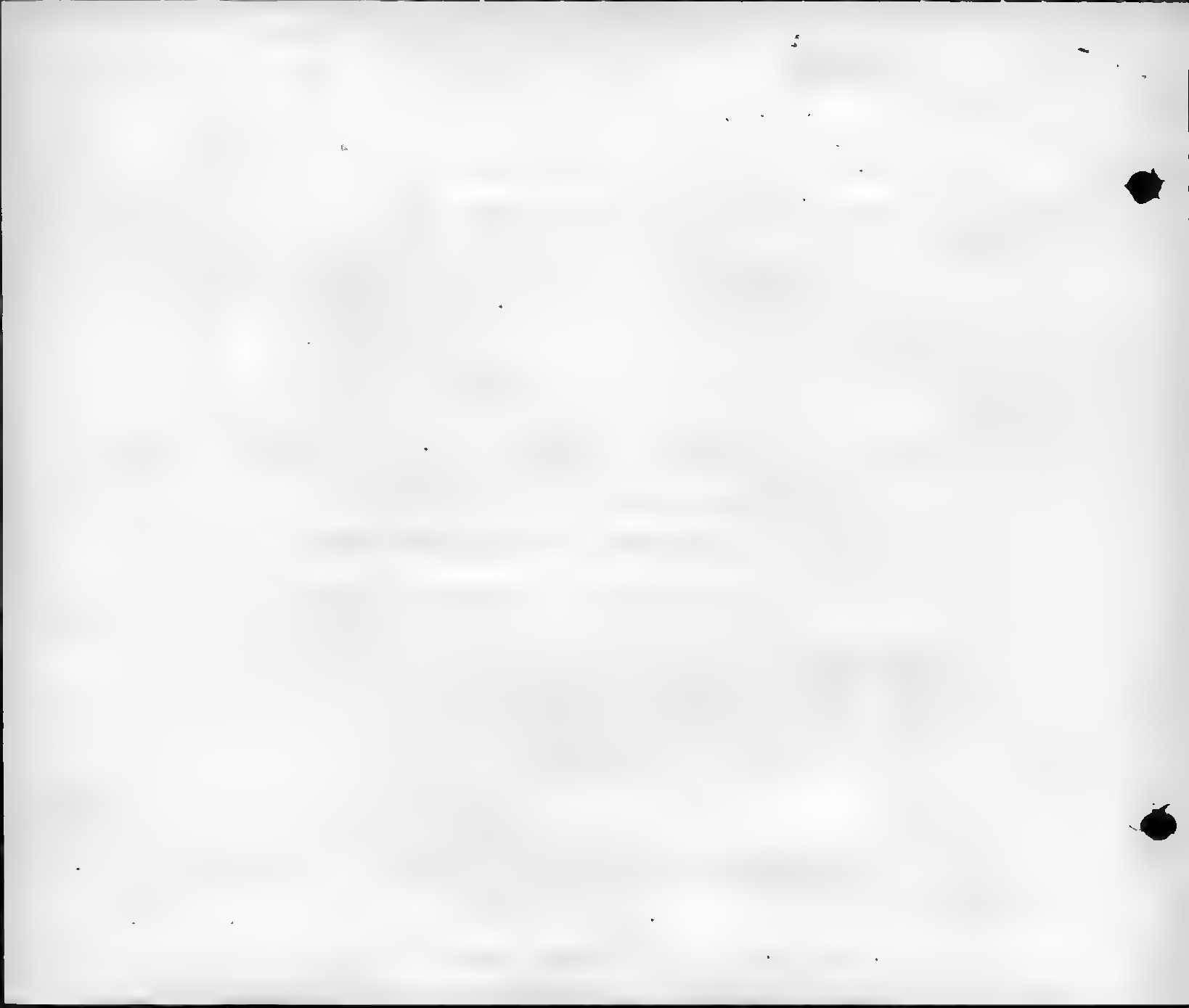
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Montgomery</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda</p> <p>c. LENGTH OF STAY IN 1b 10 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinical Center, NIH</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)</p> <p>a. STATE New Jersey b. COUNTY X</p> <p>c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Montclair East Orange</p> <p>d. STREET ADDRESS 13 Academy Street</p> <p>• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) Willie</p> <p>5. SEX Male</p> <p>6. COLOR OR RACE Negro</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Laborer</p>		<p>4. DATE OF DEATH December 7 19 60</p> <p>8. DATE OF BIRTH Oct. 6, 1925</p> <p>9. AGE (In years, last birthday) 35 yrs.</p> <p>11. BIRTHPLACE (State or foreign country) New Jersey</p> <p>12. CITIZEN OF WHAT COUNTRY? U.S.</p>	
<p>13. FATHER'S NAME Will Robinson</p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, (If yes give year or dates of service)) Yes U.S. Army, WWII</p>		<p>14. MOTHER'S MAIDEN NAME Maggie Hendley</p> <p>16. SOCIAL SECURITY NO. Not avail.</p> <p>17. INFORMANT Patient</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 436.9 DUE TO Traumatic Aortic Insufficiency, Post-op.</p> <p>Conditions (any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 6 months</p> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) Chest crushed while unloading heavy box</p>		<p>20c. TIME OF INJURY Month, Day Year Apr. May 1960</p> <p>20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> Unknown</p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>Address (Street, city, town, or county) 12-8-60</p>			
<p>ACTUAL SIGNATURE Frank J. Brasch M.D.</p> <p>EXAMINER'S NAME (Type) FRANK J. BRASCH</p>		<p>DATE SIGNED 12-8-60</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Interment</p> <p>22b. DATE THEREOF Dec 8 1960</p> <p>22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery</p>		<p>22d. LOCATION (City, town, or county) (State)</p>	
<p>23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md.</p>		<p>24a. REC'D BY REGISTRAR DEC 15 '60</p> <p>24b. REGISTRAR'S SIGNATURE Arthur L. Hanks</p>	



may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

<p>14189</p> <p>1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND</p>		<p>2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u></p>	
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u></p>	
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u></p>		<p>d. STREET ADDRESS <u>14424 - Rose Dale Ave.</u></p>	
<p>3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Alice Rogers</u></p>		<p>4. DATE OF DEATH Month Day Year <u>Dec. 31 1960</u></p>	
<p>5 SEX <u>female</u></p>		<p>6. COLOR OR RACE <u>white</u></p>	
<p>7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8 DATE OF BIRTH <u>March 23 1884</u></p>	
<p>9 AGE (In years last birthday) <u>76</u> yrs.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u></p>	
<p>11 BIRTHPLACE (State or foreign country) <u>Houtzdale, Pa.</u></p>		<p>12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>John Brady</u></p>		<p>14. MOTHER'S M maiden name <u>Rose Timberline</u></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>None</u></p>	
<p>17. INFORMANT <u>Rose Marie Rogers</u></p>		<p>Address <u>Same As Above</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral infarction</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>			
<p>INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u></p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21 I certify that (I) (this hospital) attended the deceased from <u>12-10</u> 19 <u>60</u> to <u>12-31</u> 19 <u>60</u>, that (I) (we) lost saw the deceased alive on <u>12-31</u> 19 <u>60</u>, and that death occurred at <u>5:30</u> M. from the causes and on the date stated above</p>			
<p>22a. SIGNATURE <u>Michel M. Healy</u></p>		<p>22b. DATE SIGNED <u>12/31/60</u></p>	
<p>22c. PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u></p>		<p>22d. ADDRESS <u>5523 Trent St. Chevy Chase, Md.</u></p>	
<p>23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>1/3/61</u></p>	
<p>23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u></p>		<p>23d. LOCATION (City, town or county) <u>Houtzdale, Penna.</u> (State)</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u></p>		<p>25a. REC'D BY REGISTRAR <u>Jan 3 '61</u></p>	
<p>ADDRESS <u>Bethesda, Maryland</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u></p>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

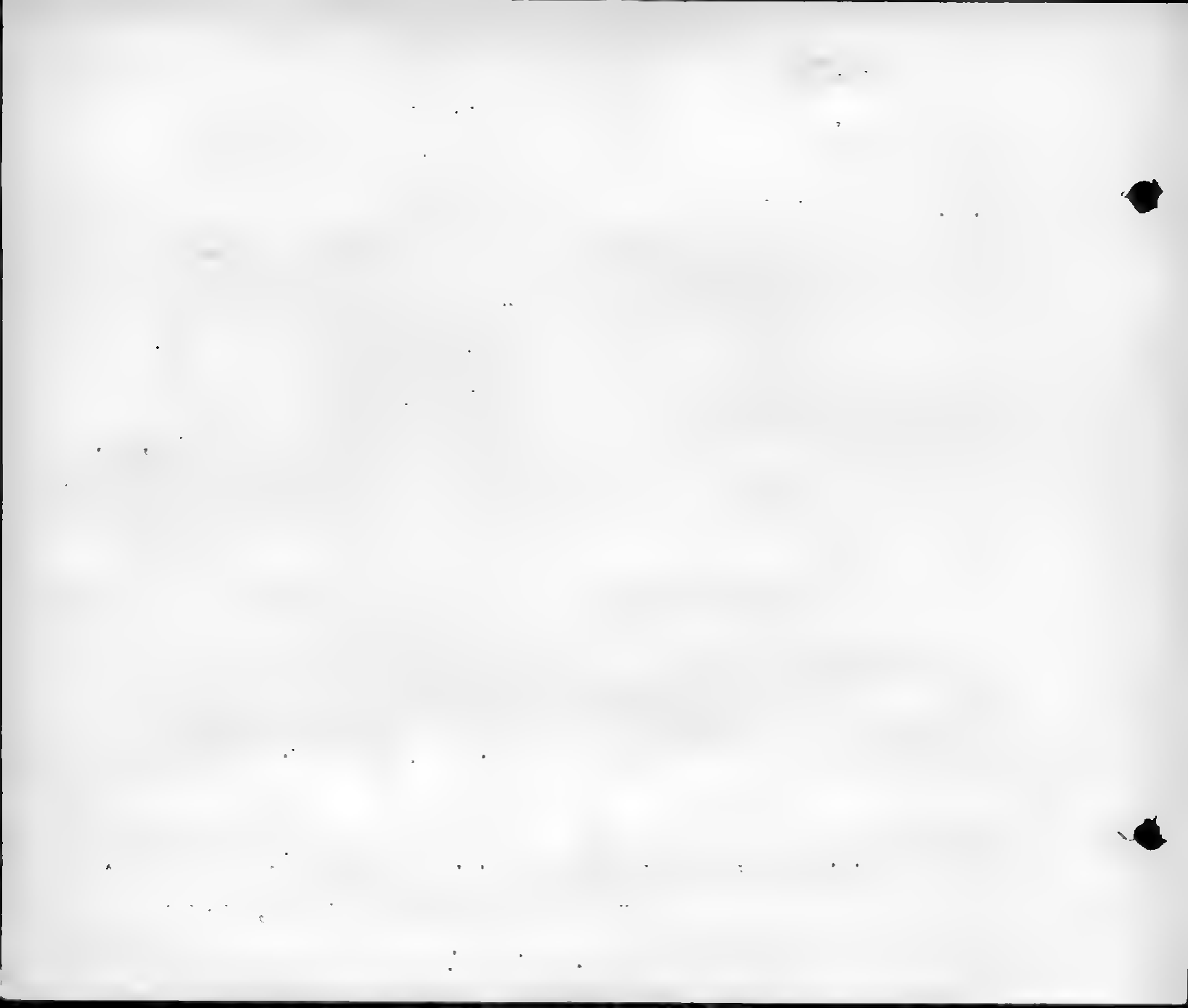
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14190

14146

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY William			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 34 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Lawrence Last ROONEY				4. DATE OF DEATH Month December Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-51	
9. AGE (In years last birthday) 9 yrs		IF UNDER 1 YEAR Months 9 Days 24 Hours 15 Min.		IF UNDER 24 HRS Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) Nebraska			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Thomas ROONEY				14. MOTHER'S MAIDEN NAME Lucinda VAN METER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
				17. INFORMANT John Thomas ROONEY Qts 344 Quantico, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 Intracranial hemorrhage DUE TO 48 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombocytopenia DUE TO 2 wk. (c) Leukemia, acute DUE TO 6 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that XX (this hospital) attended the deceased from Nov. 20 1960 to Dec. 24 1960 that X (we) last saw the deceased alive on Dec 24 1960 , and that death occurred at 8:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE L. G. Thorne				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L. G. THORNE, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 28 December 60			
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home				25a. REC'D BY REGISTRAR DEC 29 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Thorne							



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

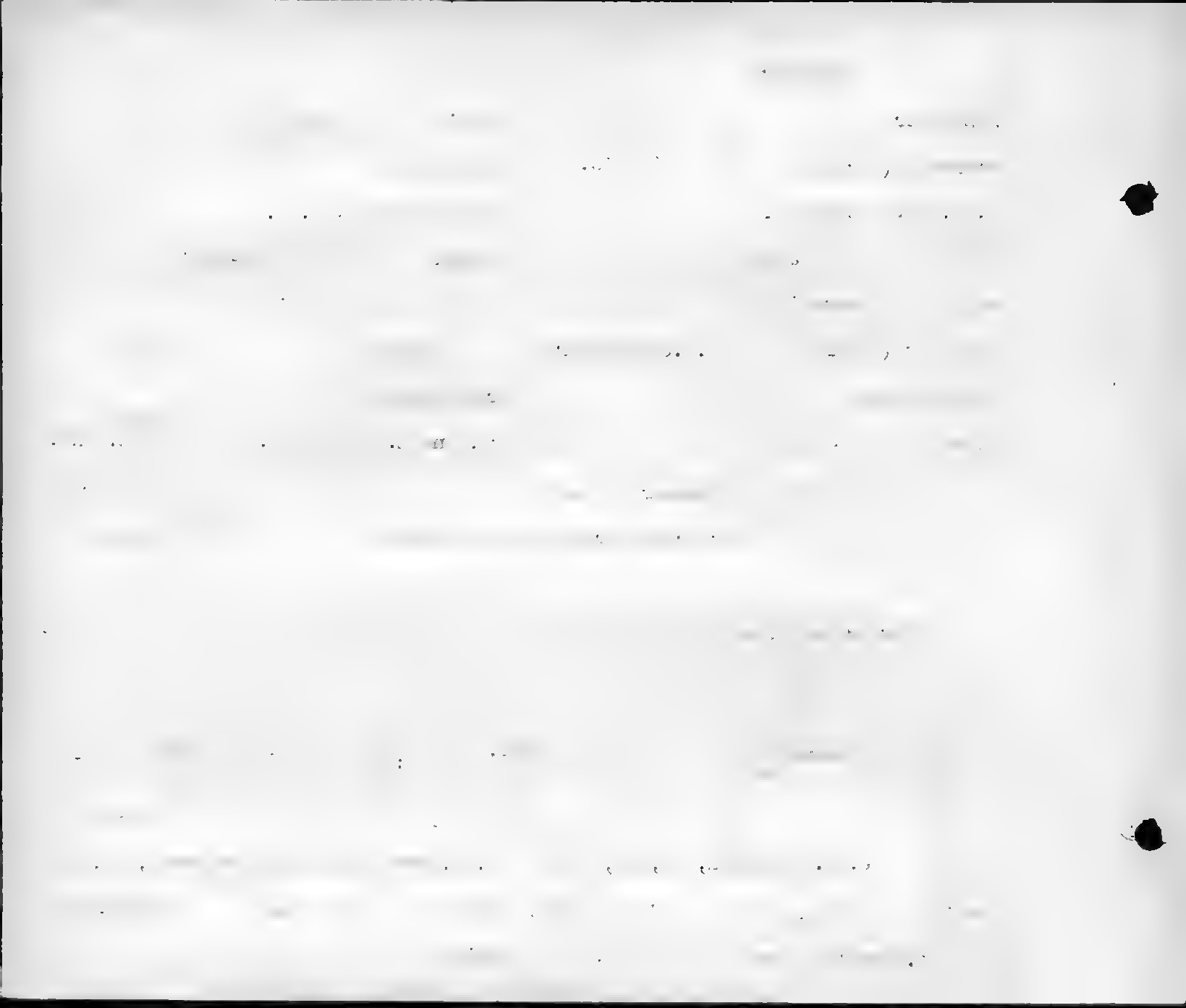
14191

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14147

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 35 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Jacob Middle ROSENBERG Last ROSENBERG				4. DATE OF DEATH Month December Day 8 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-92		9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S.Coast Guard		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max Rosenberg				14. MOTHER'S MAIDEN NAME Sarah SINGMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WWI - WWII		17. INFORMANT (W) Mrs. Ann L. Rosenberg, 5812 7th St., NW,		Address WashDC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)							years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home form factory street office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) Witnessed attended the deceased from Dec. 8 19 60 to Dec. 8 19 60 , that (I) (xx) last saw the deceased alive on Dec. 8 19 60 , and that death occurred at 12:05 PM M, from the causes and on the date stated above.							
22a. SIGNATURE J. E. Stitcher M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-9-60	
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-11-60		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery		23d. LOCATION (City, town, or county) (State) Oxon Hill Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home				25a. REC'D BY REGISTRAR DEC 12 '60		25b. REGISTRAR'S SIGNATURE Arthur J. ...	

14191



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

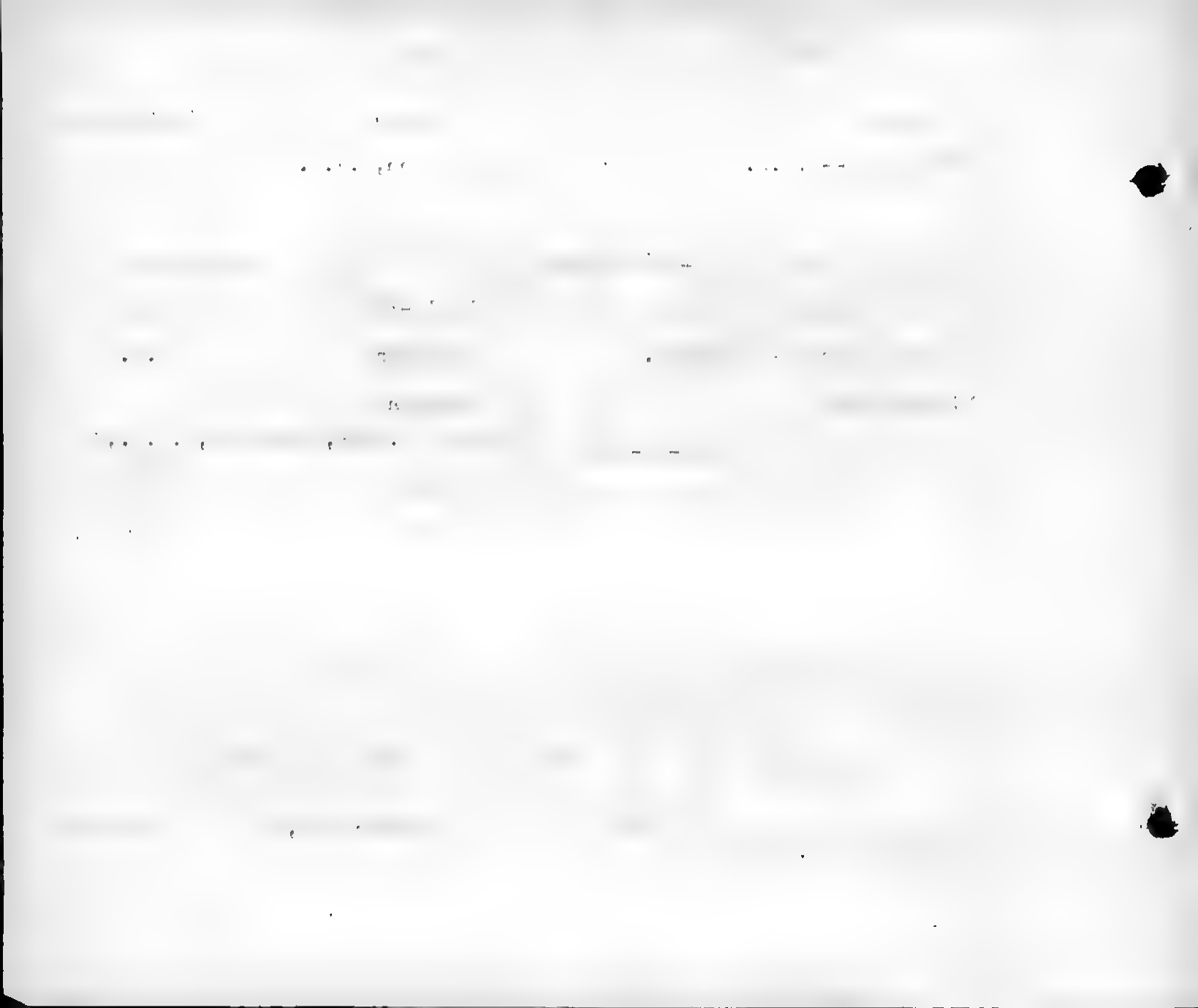
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14192

CERTIFICATE OF DEATH

Reg. Dist. No. 14148

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson--R.F.D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson, R.F.D.	
c. LENGTH OF STAY IN 1b 8 yrs		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
3. NAME OF DECEASED (Type or print) Earl William Rowe		4. DATE OF DEATH December 20 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15-1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer--Bechtel Const Co.		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Rowe		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 224-12-7424	
17. INFORMANT Mrs Earl W. Rowe, Dickerson, R.F.D., Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Dec. 1960 to 20 Dec. 1960 , that I last saw the deceased alive on 19 Dec. 1960 , and that death occurred at Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 12/20/60	
PHYSICIAN'S NAME (Type) Gordon M. Smith		M.D. Barnesville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/60	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Bethesda Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton		24a. REC'D BY REGISTRAR DEC 23 '60	
ADDRESS Barnesville Md		24b. REGISTRAR'S SIGNATURE James E. Kiser	



CERTIFICATE OF DEATH

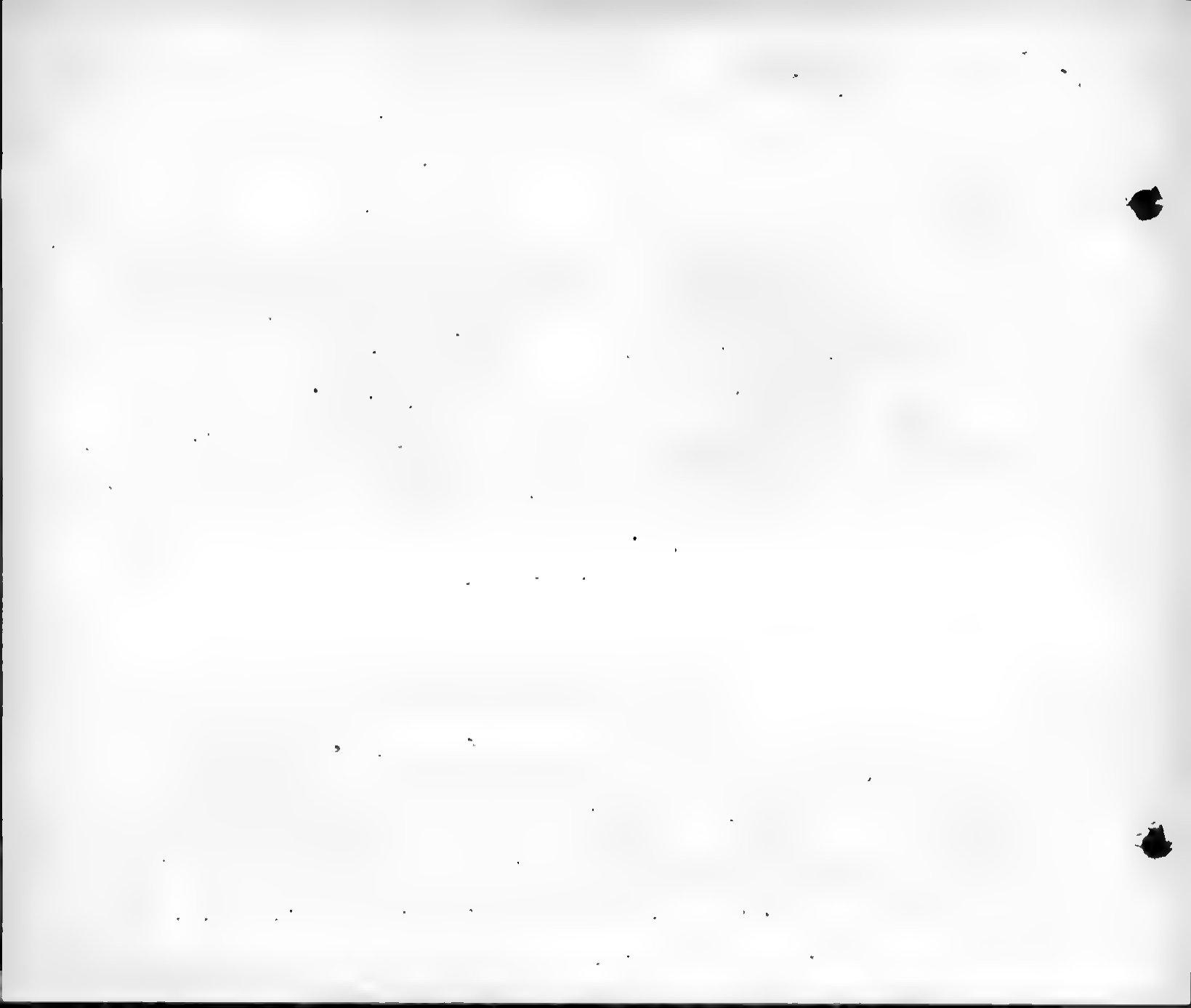
Reg. Dist. No. 14149

14193

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New York State b. COUNTY Long Island	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jamaica, Long Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 8715 165th St.	
3. NAME OF DECEASED (Type or print) First Leonard W. Middle Rutledge Last 		4. DATE OF DEATH Month Dec. Day 14 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/95
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer-ret.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Martin Rutledge	
14. MOTHER'S MAIDEN NAME Mary Leonard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Mexican	
16. SOCIAL SECURITY NO. None		INFORMANT Thomas J. McCoy Address 4606 Singleton Rd. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TOXEMIA			
154X DUE TO Metastatic Carcinoma			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Ovarian Carcinoma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to Dec 13, 1960 , that I last saw the deceased alive on Dec 13 19 60 , and that death occurred at 1:45 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo I. Demovany MD		ADDRESS (Street, city or town, state) 8218 WINDOMAR AVE 13/14/60	
PHYSICIAN'S NAME (Type) LEO I DEMOVANY MD		BETHESDA MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Bur-transir	12/17/60	St. Lawrence Cemetery	Sayville, L.I. New York
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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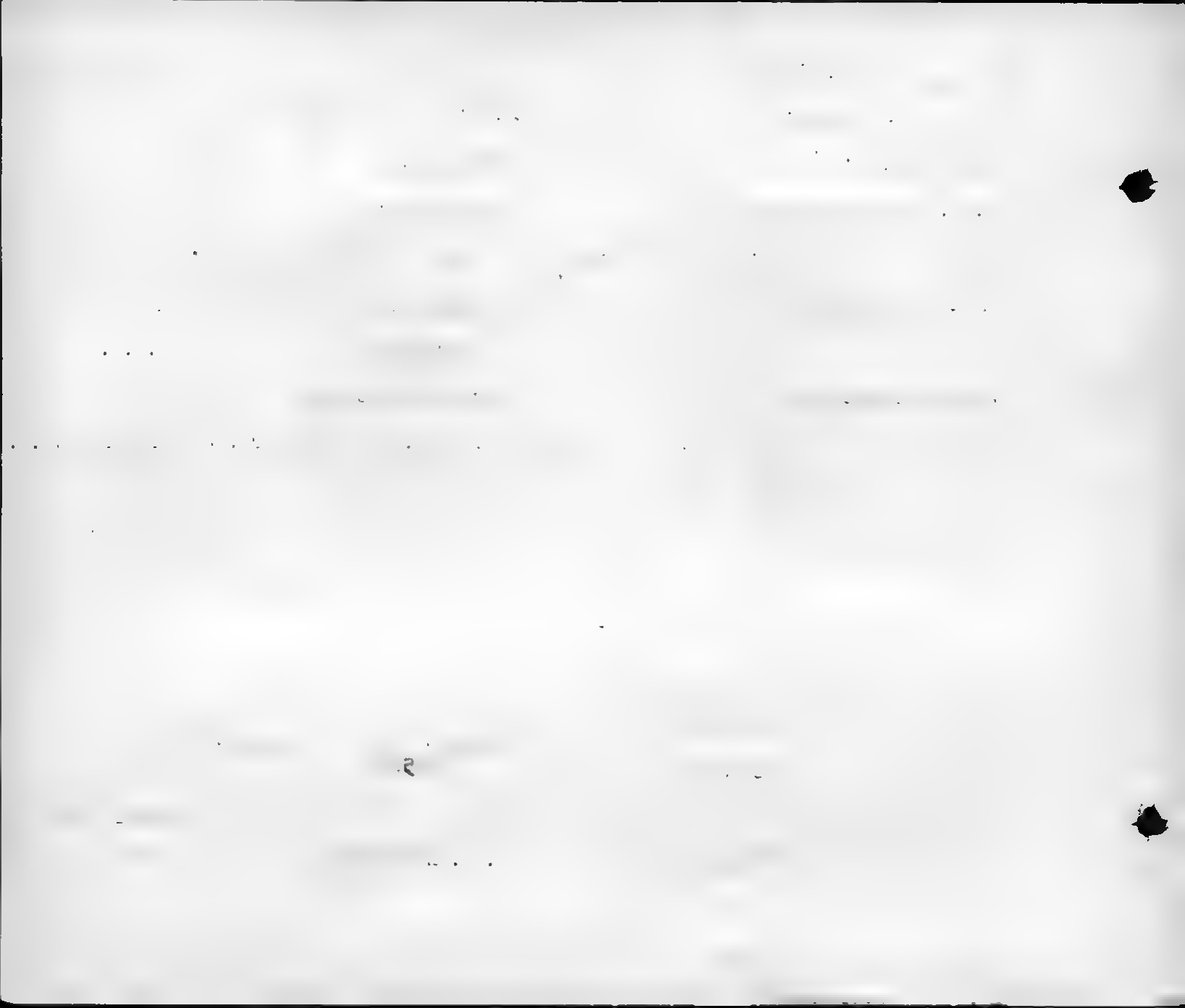


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14194

14150

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Patrick Middle Michael Last RYAN				4. DATE OF DEATH Month December Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 September 1960	9. AGE (In years last birthday) yrs 3 Months 1 Days 1 Hours 1 Min	10. KIND OF BUSINESS OR INDUSTRY, 11. BIRTHPLACE (State or foreign country) Maryland		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Arnold Ryan				14. MOTHER'S MAIDEN NAME Dorothy Lee Cowher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Joseph A. Ryan, 4945 Deal Dr., Washington 21, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPOXIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PNEUMONIA, STAPHYLOCOCCUS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 36 HOURS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction age 2 months.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2 December 1960 to 3 December 1960 , that (I) was lost saw the deceased alive on 3 December 1960 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Rack		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3 December 1960			
22c. PHYSICIAN'S NAME (Type) Robert V. Rack, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		ADDRESS 1601 14th St NW Wash DC		25a. REC'D BY REGISTRAR DEC 6 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14053

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; if deceased has been in institution, write name of institution) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8527 11th Ave</u>	
3. NAME OF DECEASED (Type or print) <u>John Forte Sandison</u>		4. DATE OF DEATH Dec. 26 1960	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-83</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sandison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Chapman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>W.S. Hospital Records</u>	
17. INFORMANT <u>W.S. Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (e), stating the underlying cause last.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20a. <u>Coronary artery Sclerosis</u> 20b. <u>Probable Multiple myeloma</u>			
21. I certify that (I) (this hospital) attended the deceased from Dec. 24, 1960 to Dec. 26, 1960, that (I) (we) last saw the deceased alive on Dec. 26, 1960, and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen, M.D.</u>		22b. DATE SIGNED <u>Dec. 26, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gene U. Cohen, M.D.</u>		22d. ADDRESS <u>431 Pershing Drive Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) <u>Gaithersburg</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Gault</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

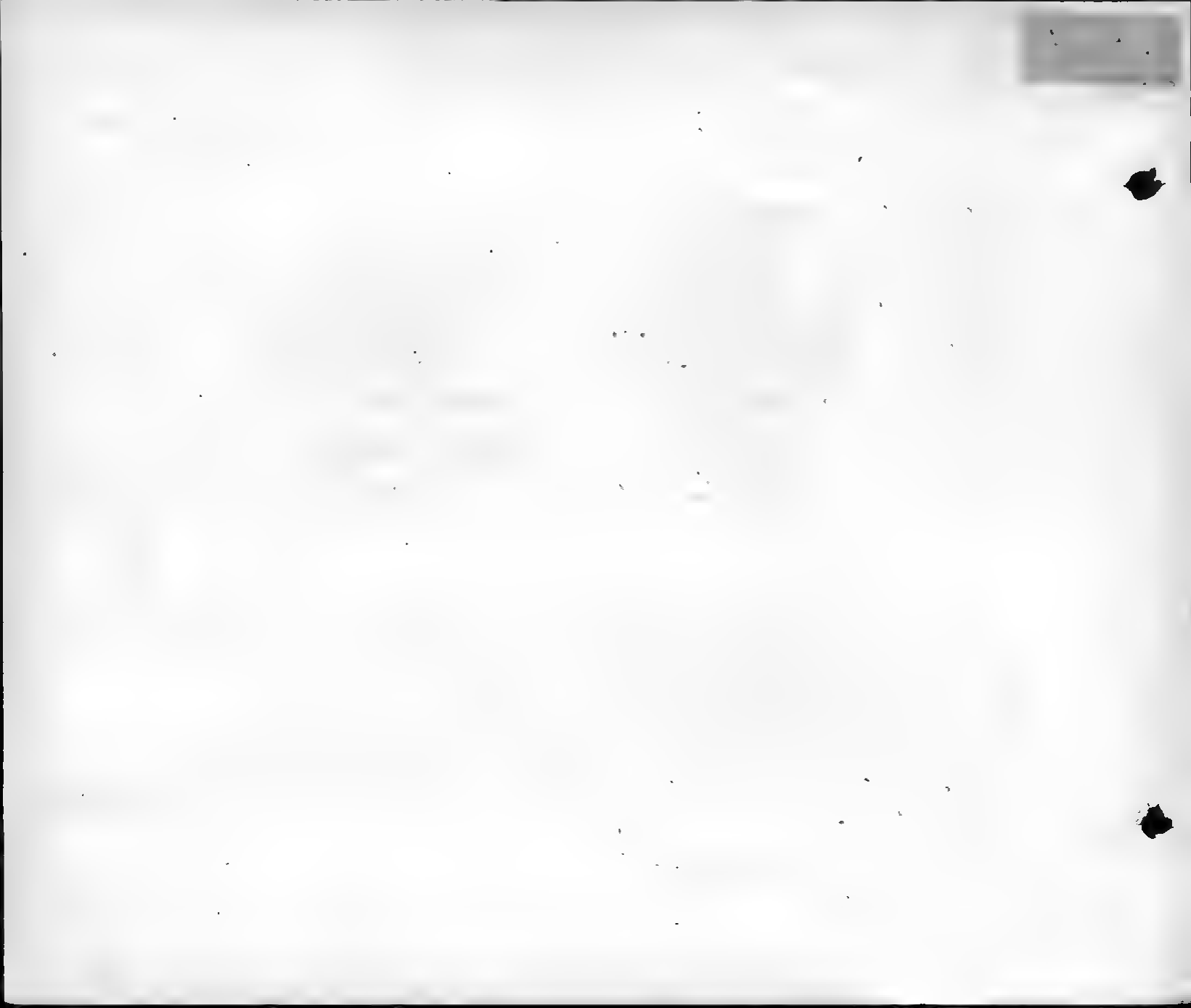
Reg. Dist. No. 14152

14195

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If instit on. Res dence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Potomac</u>		c LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ropine Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilda Darnall Sanford</u>		4. DATE OF DEATH <u>Dec 1 1960</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 18, 1897</u> 9 AGE (In years last birthday) <u>63 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Gov't Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip H. Darnall</u>		14. MOTHER'S MAIDEN NAME <u>Marian Sheirburn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>?</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 33 IX DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/29, 1960</u> to <u>12/1, 1960</u> that I last saw the deceased alive on <u>11/29, 1960</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Karchmill Rd. Rockville, Md.</u>			
ACTUAL SIGNATURE <u>Jerman Chupaz</u> M.D.		DATE SIGNED <u>12/1/60</u>	
PHYSICIAN'S NAME (Type) <u>809 Karchmill Rd. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Katie Drew. Newaco, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 12 60</u>	24b. REGISTRAR'S SIGNATURE <u>H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.



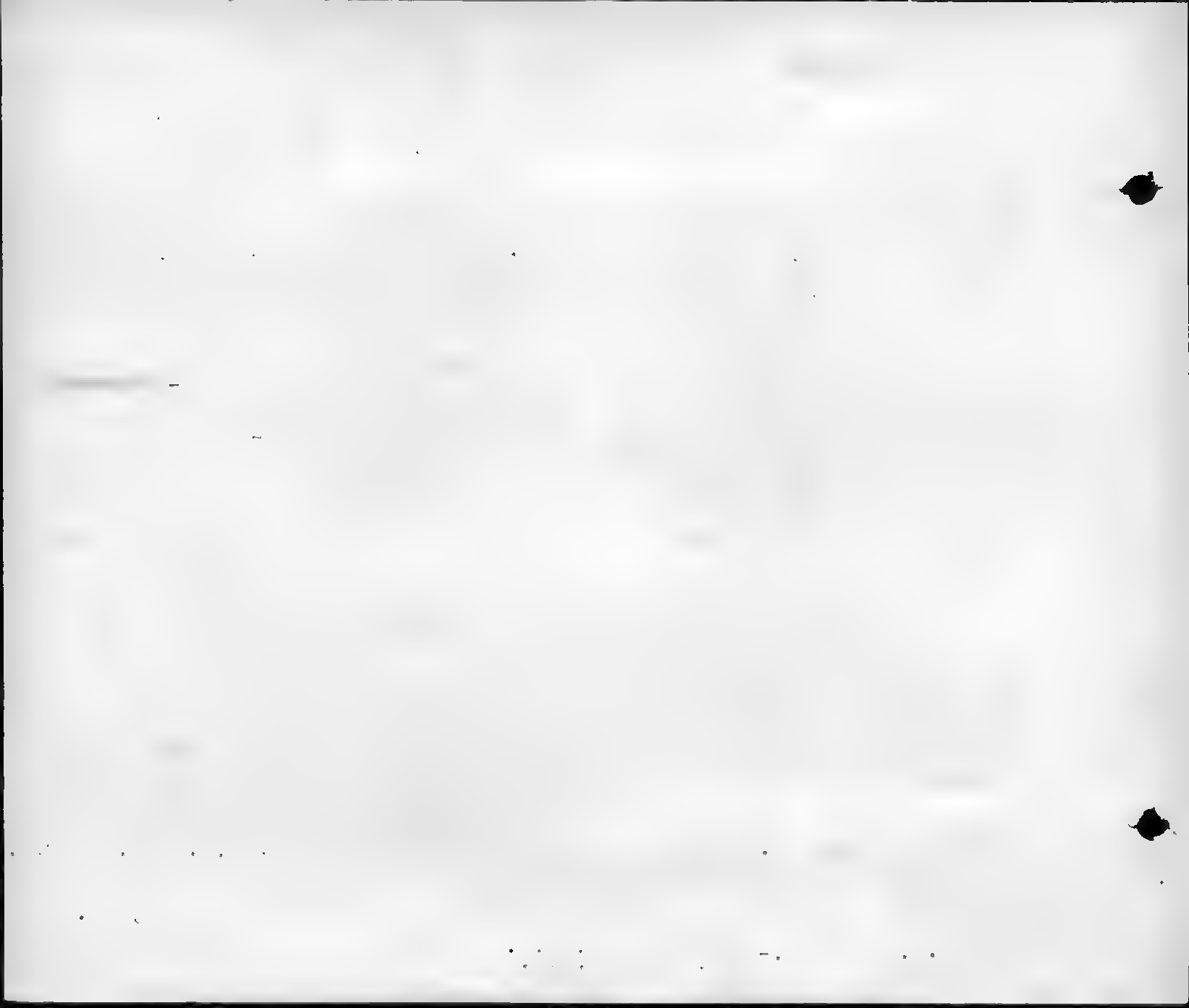
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

141196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14153

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver - Springs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>125 E. Wayne Ave. Apt. 512</i>	
3. NAME OF DECEASED (Type or print) <i>George Thomas Santmyers</i>		4. DATE OF DEATH <i>Dec 26 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 15 - 1890</i>
9. AGE (In years last birthday) <i>70 yrs</i>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last 6 months of working life, even if retired) <i>Architect</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Williams</i>		14. MOTHER'S MAIDEN NAME <i>Katheryn Sacks -</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>220-34-8350</i>	
17. INFORMANT <i>Dorothy Santmyers - Same #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA, STOMACH & METASTASES</i> DUE TO (b) <i>EMPHYSEMA, PULMONARY</i> DUE TO (c) <i>151X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i> <i>10 YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <i>12-20 1960</i> to <i>12-26 1960</i> , that (I) (we) last saw the deceased alive on <i>12-20 1960</i> , and that death occurred at <i>7:30 AM</i> from the causes and on the date stated above			
22a. SIGNATURE <i>Philip R. James</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Philip R. James</i>		22d. ADDRESS <i>5401 Western Ave., N.W. Wash. 15, D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/28/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		25a. REC'D BY REGISTRAR <i>DEC 29 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Caroline L. Hines</i>		25c. ADDRESS <i>2901 14th St., N.W. Washington 9, D.C.</i>	



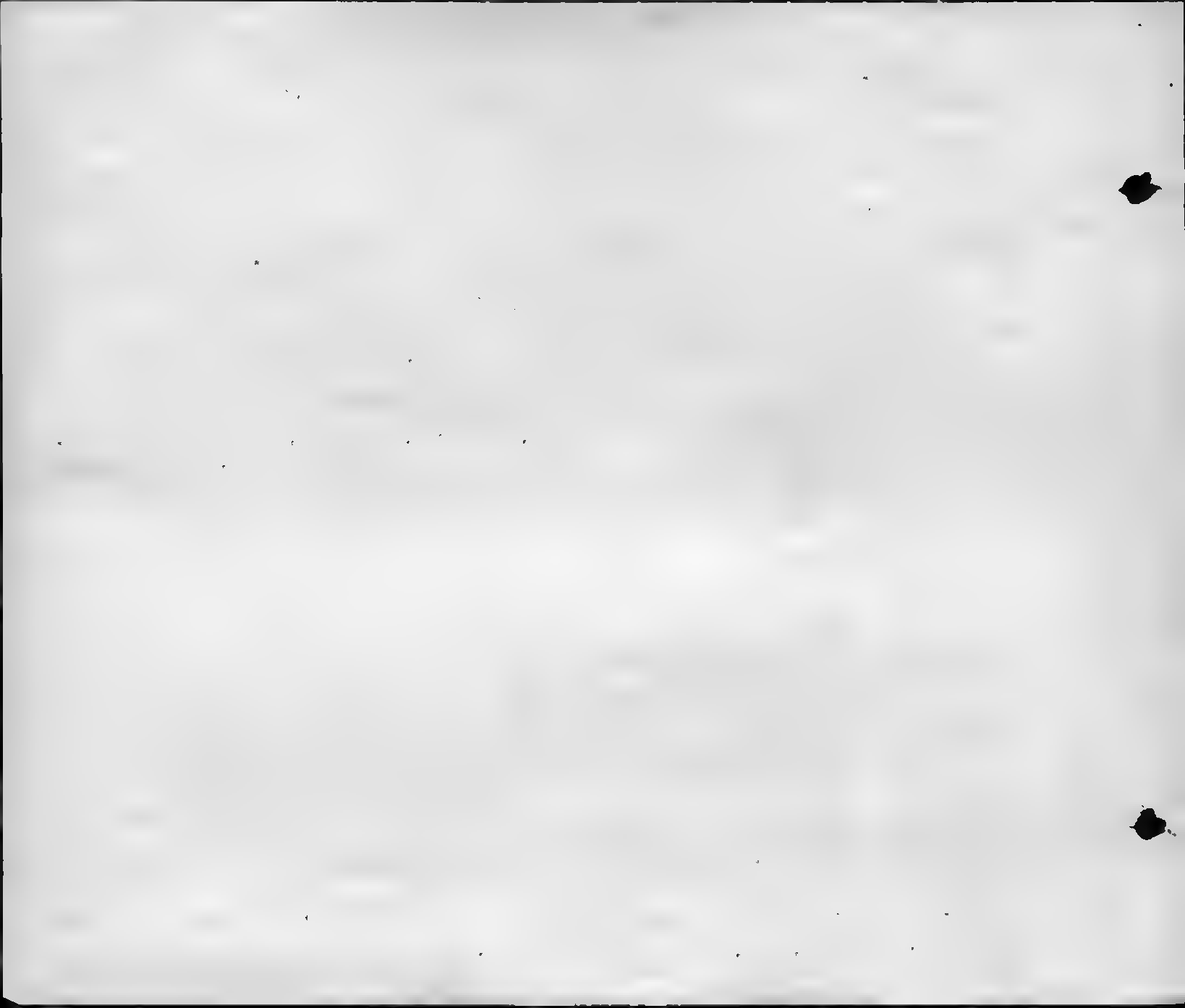
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14154											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE GERMANY				b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMBURG			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1840 EAST-WEST HIGHWAY				d. STREET ADDRESS 39 WINTERHUEDER KAI				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERTRUDE ELISE HENRIETTE SAUER				4. DATE OF DEATH DEC. 20 19 60				5. SEX FEMALE			
6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3/15/01			
9. AGE (In years last birthday) 59				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				11. BIRTHPLACE (State or foreign country) GERMANY			
12. CITIZEN OF WHAT COUNTRY? GERMANY				13. FATHER'S NAME HEINRICH PAYSSEN				14. MOTHER'S MAIDEN NAME EMILIE GLASHOFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Luther K. Baughams, 1840 East-West Hwy. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1 + 2 0.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. INTERVAL BETWEEN ONSET AND DEATH sudden											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 12-20-60											
ACTUAL SIGNATURE Frank J. Broschart M.D.											
EXAMINER'S NAME (Type) FRANK J. BROSCART											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL											
22b. DATE THEREOF 1/5/61											
22c. NAME OF CEMETERY OR CREMATORY											
22d. LOCATION (City, town, or country) (State) HAMBURG, GERMANY											
23. FUNERAL DIRECTOR WARREN E. PIMPHRY, INC.											
ADDRESS SILVER SPRING, MD.											
24a. REC'D BY REGISTRAR DEC 27 '60											
24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss											

MEDICAL CERTIFICATION



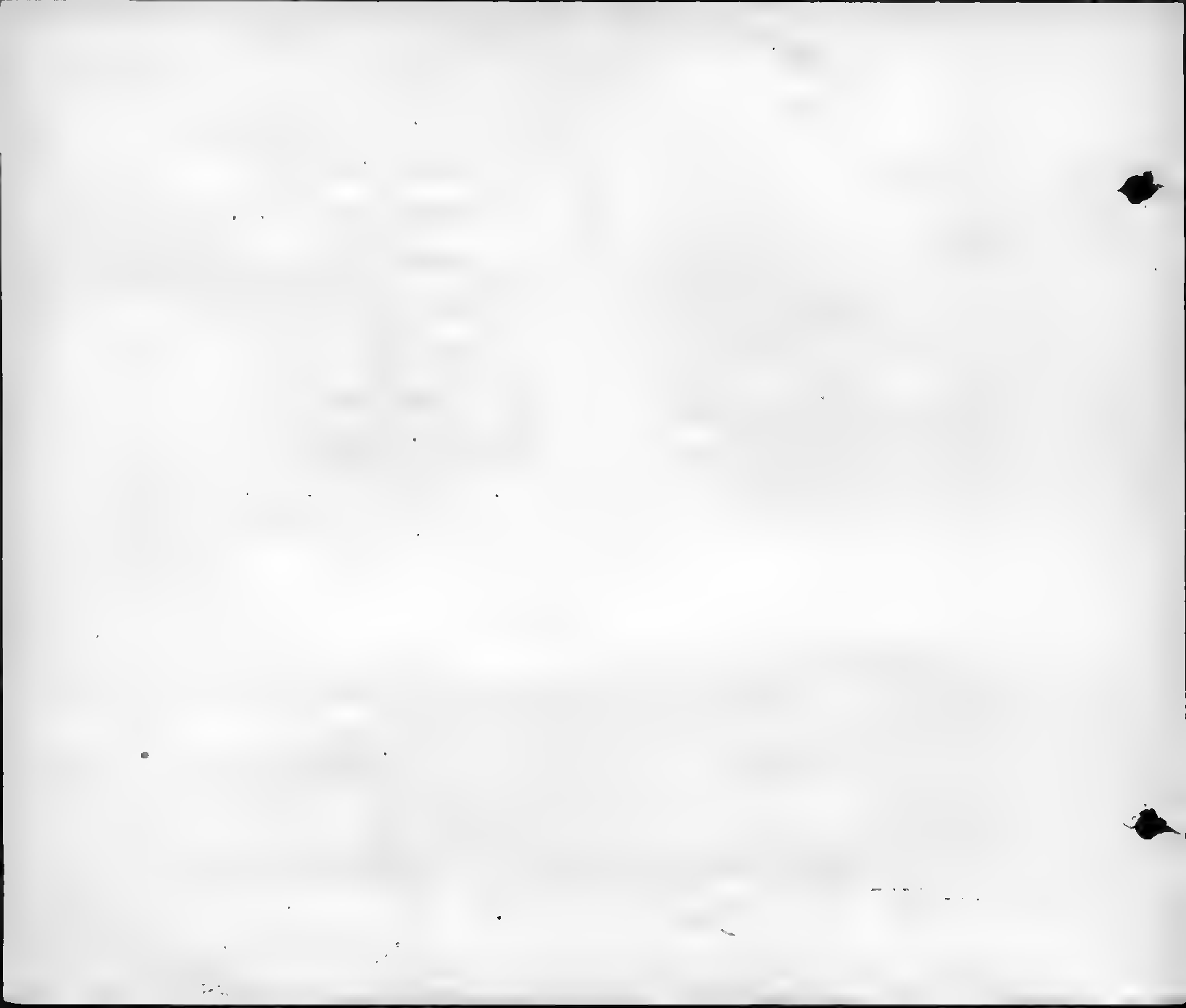
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14155

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived) (If institution, Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS WASHINGTON			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3299 Arcadia Place N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER R SCHMITT				4. DATE OF DEATH Month Day Year DEC. 11 19 60			
5. SEX MALE		6. COLOR OR RACE WH ITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/20/97	
9. AGE (In years lost birthday) 63 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY NEW YORK			
13. FATHER'S NAME ROBERT F. SCHMITT				14. MOTHER'S MAIDEN NAME EMMY PABST			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO WORLD WAR I			
17. INFORMANT Blanche E. Schmitt Address WIFE (SAME AS ABOVE) # 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema + Cardiac failure DUE TO 16 - 1 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO 5 mo (c) Primary Pulmonary Adenocarcinoma 1 yr 2				INTERVAL BETWEEN ONSET AND DEATH 10 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1960 to Dec 11, 1960 that (I) (we) last saw the deceased alive on Dec 11 1960 and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Taylor				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR				22d. ADDRESS Washington Clinic, Washington 15, D.C.			
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> burial				23b. DATE THEREOF 12/14/60			
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery				23d. LOCATION (City, town, or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE St. Hines Co.				25a. REC'D BY REGISTRAR DEC 14 '60			
ADDRESS 2901 14th NW				25b. REGISTRAR'S SIGNATURE C. Hines			

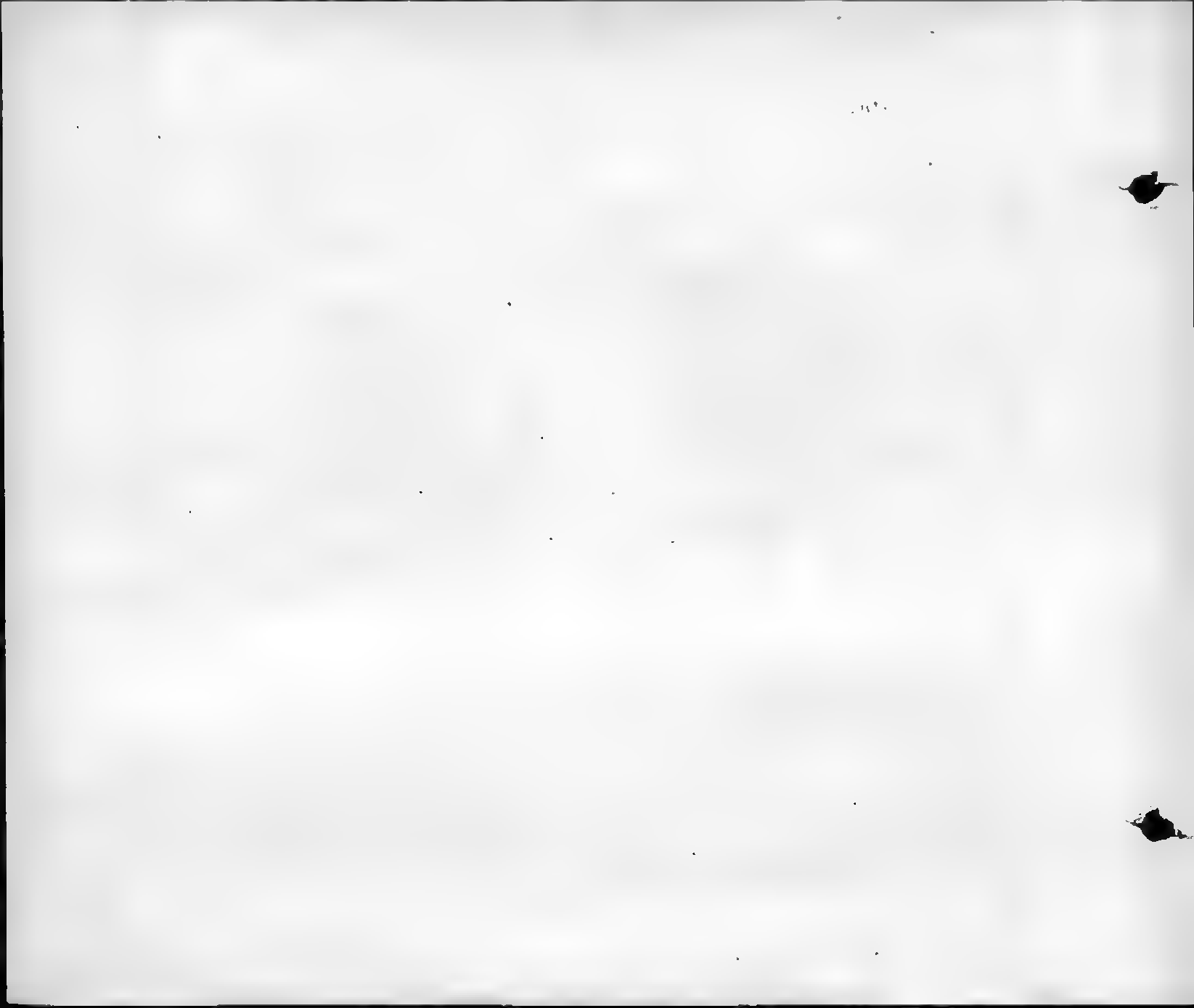


14054

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14156

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>51 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7402 Canwell Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOTA</u> First <u>LOTHA</u> Middle <u>FERN</u> Last <u>Schofield</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-89</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bake decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William H. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Emma Reg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>Washington Sanatorium & Hospital</u>	
17. INFORMANT <u>Washington Sanatorium & Hospital</u>		Address <u>Washington Sanatorium & Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 24, 1960</u> to <u>Dec 14, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 13, 1960</u> , and that death occurred at <u>7:45 A</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Roblein</u>		22b. DATE SIGNED <u>Dec 14, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 University Blvd. S. S. Md.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 16, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Rensselaer Park</u>	23d. LOCATION (City, town, or county) (State) <u>Prince George Co Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur White</u>		25a. REC'D BY REGISTRAR <u>DEC 19 '60</u>	
ADDRESS <u>254 Canwell St NW</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. Frank</u>	



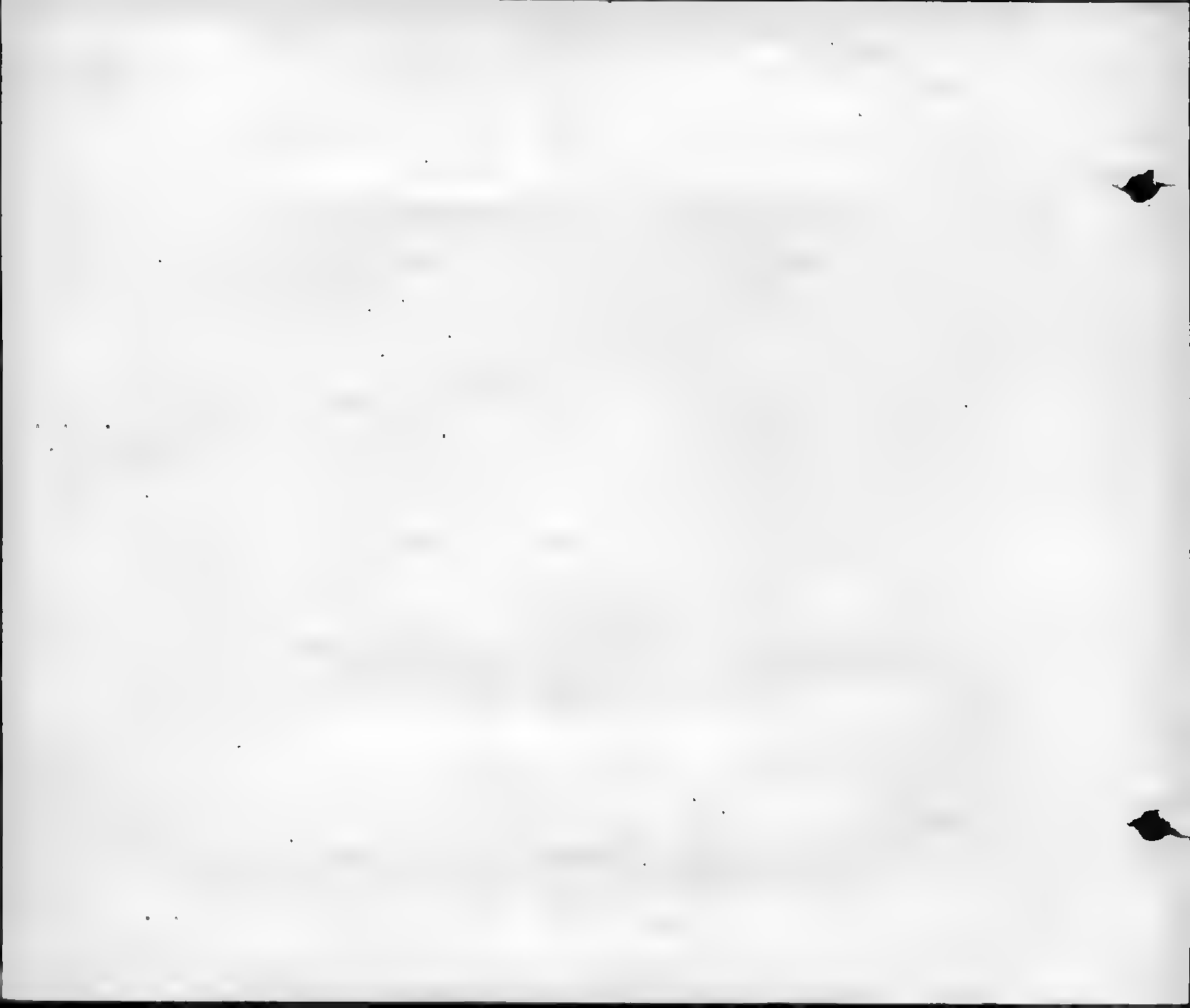
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14075
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14157

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>47X 2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>		d. STREET ADDRESS <u>5603-2nd St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELEANOR</u> Middle <u>B.</u> Last <u>SHANNON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24, 1891</u>		9. AGE (In years lost birthday) yrs <u>69</u>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Defense Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert A Shannon</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Griffith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Aldora S. Schmidt</u>		Address <u>5603 2nd St. N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>15 yrs</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1960</u> to <u>Dec. 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 22, 1960</u> , and that death occurred at <u>5 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel M. Bageant</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT</u>				22d. ADDRESS <u>5600 N. H. Ave. Wash., D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Jones Co. Washington D.C.</u>				25a. REC'D BY REGISTRAR <u>JAN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

I



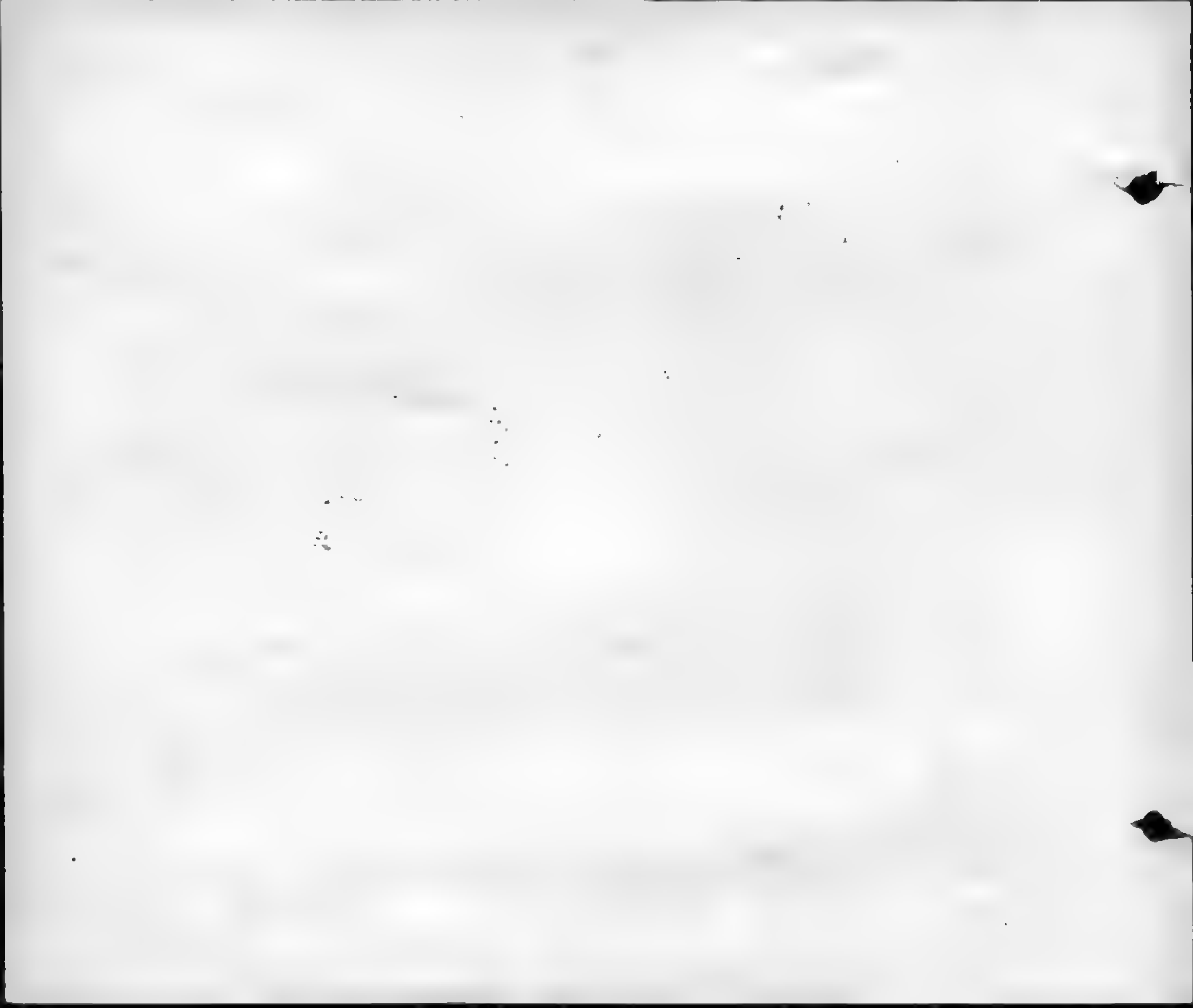
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14198

14158

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Rockville			
				d. STREET ADDRESS 412 Anderson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret E. Shannon		First Middle Last		4. DATE OF DEATH Month Dec. Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH I/ 6/88		9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Grley B. Neal				14. MOTHER'S MAIDEN NAME Marion Margaret Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Jasper Shannon Address 412 Anderson Ave. Rockville MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4:20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) Essential Hypertension						INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs indist	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/5/60 to 12/7/60 , that (I) (we) last saw the deceased alive on 12/7/60 , and that death occurred at 4:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Stephen N. Jones		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/7/60			
22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22d. ADDRESS 809 Union Mill Rd. Rockville MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/10/60		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION (City, town, or county) (State) Rockville MD	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton				25a. RECEIVED BY REGISTRAR DATE DEC 9 '60		25b. REGISTRAR'S SIGNATURE C. Hunt & Grand	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14159

14199

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>4414 Highland Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bldg. 124 Nat. Naval Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis R Shearer</u>		4. DATE OF DEATH <u>12 22 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1908</u>
9. AGE (in years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repair man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat. Naval Med Cen.</u>	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey E. Shearer</u>		14. MOTHER'S MAIDEN NAME <u>Nattie Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO <u>3-230</u>	
17. INFORMANT <u>Edna M. Shearer - same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrall Edema</u> DUE TO (b) <u>Cerebrall Contusions</u> DUE TO (c) <u>Fracture of skull</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hrs. ?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Apparently fell from ladder</u>	
20c. TIME OF INJURY Month, Day, Year <u>12 22 19 60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bldg. 124 N.N.M.C.</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. File its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14160

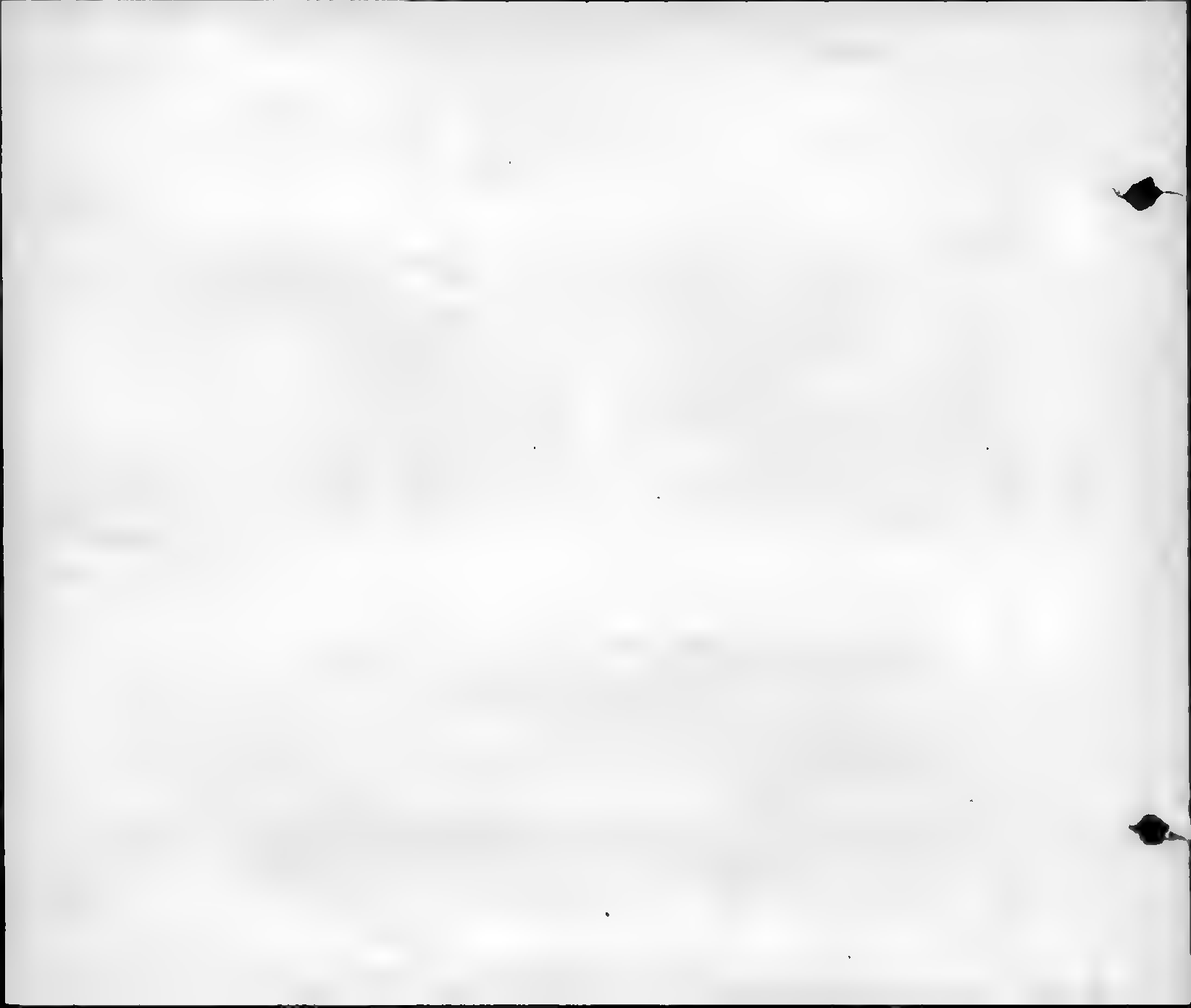
1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1228 Eye Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Carl Middle Reginald Last Sjostrom				4 DATE OF DEATH Month December Day 28 Year 1960			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH December 29, 1892	
9 AGE (in years last birthday) 67 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rug Service		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME Paul R. Sjostrom			
14. MOTHER'S MAIDEN NAME Emma Wright				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes World War I			
16. SOCIAL SECURITY NO				17 INFORMANT Washington Sanitarium & Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 581.1 DUE TO Alcoholic cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiovascular Renal Syndrome 1 year (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity						INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several days	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from July 1960 to Dec 28, 1960 , that (I) (we) last saw the deceased alive on Dec 26, 1960 , and that death occurred at 11:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Oliver E. Thompson				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) OLIVER E THOMPSON				22d. ADDRESS 1835 Eye St. N.W. Wash D.C.			
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF Dec 30, 1960		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince George County, Md	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll St. NW W.C.				25. REC'D BY REGISTRAR JAN 5 61		25b. REGISTRAR'S SIGNATURE Wm. S. Hanna	

(M)

(I)

(O)

(1)

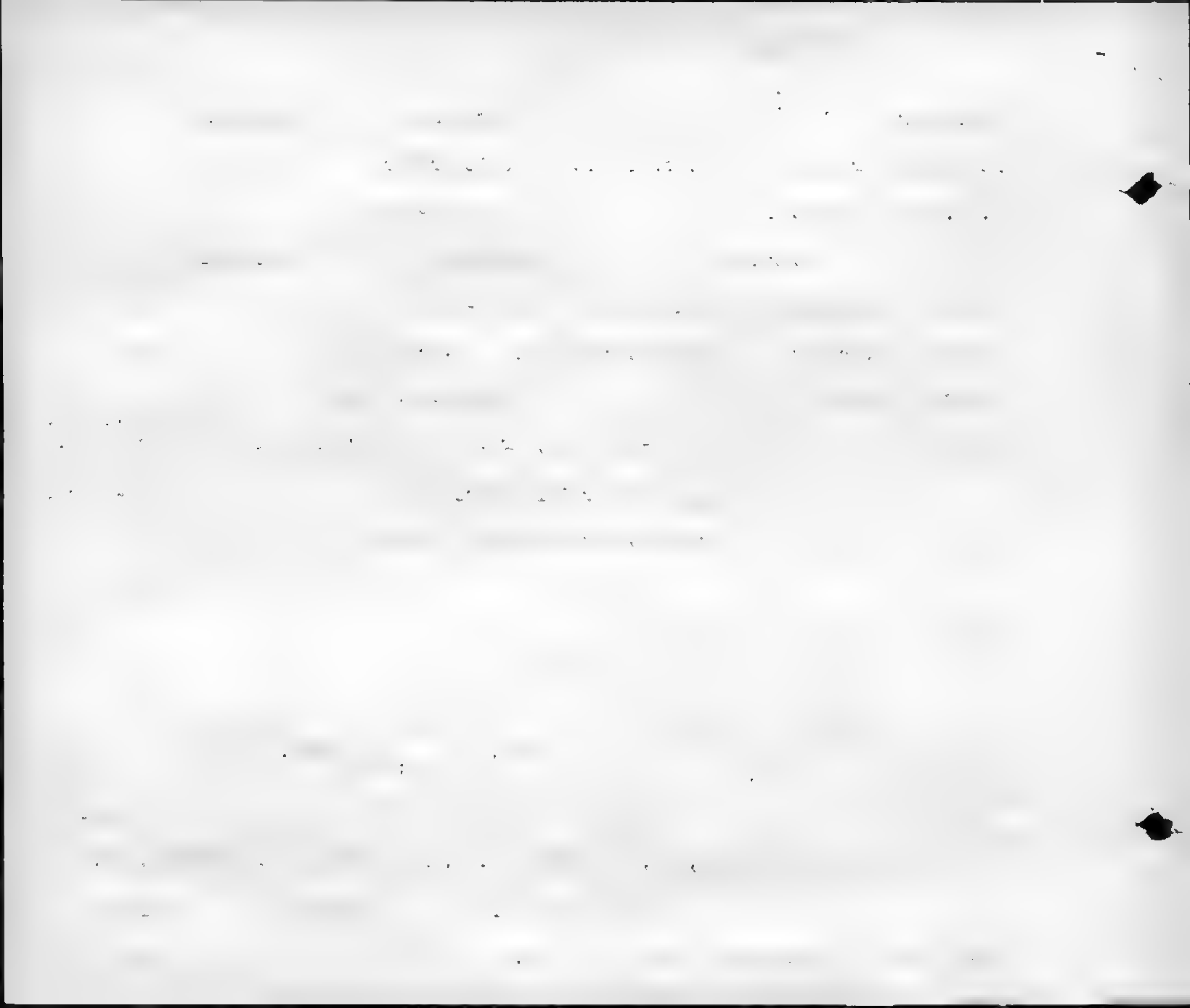


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

14200 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

14161

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Caroline				4. DATE OF DEATH December 20 1960			
5. SEX Female				6. COLOR OR RACE Caucasian			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-8-20			
9. AGE (In years last birthday) 40 yrs				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator				10b. KIND OF BUSINESS OR INDUSTRY Atomic Energy Comm.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George CORNWELL				14. MOTHER'S MAIDEN NAME Massie L. ODEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-16-0383			
17. INFORMANT (M) Mrs. Massie Cornwell, 1023 Rockcrest Dr.				Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction							
DUE TO (b) Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) xxx attended the deceased from Dec. 20 1960 to Dec. 20 1960 , that (I) xxx last saw the deceased alive on Dec. 20 1960 , and that death occurred at 10:45 PM from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker				22b. DATE SIGNED 12-21-60			
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/23/60			
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City, town, or county) (State) Rockville Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				25a. REC'D BY REGISTRAR DEC 27 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

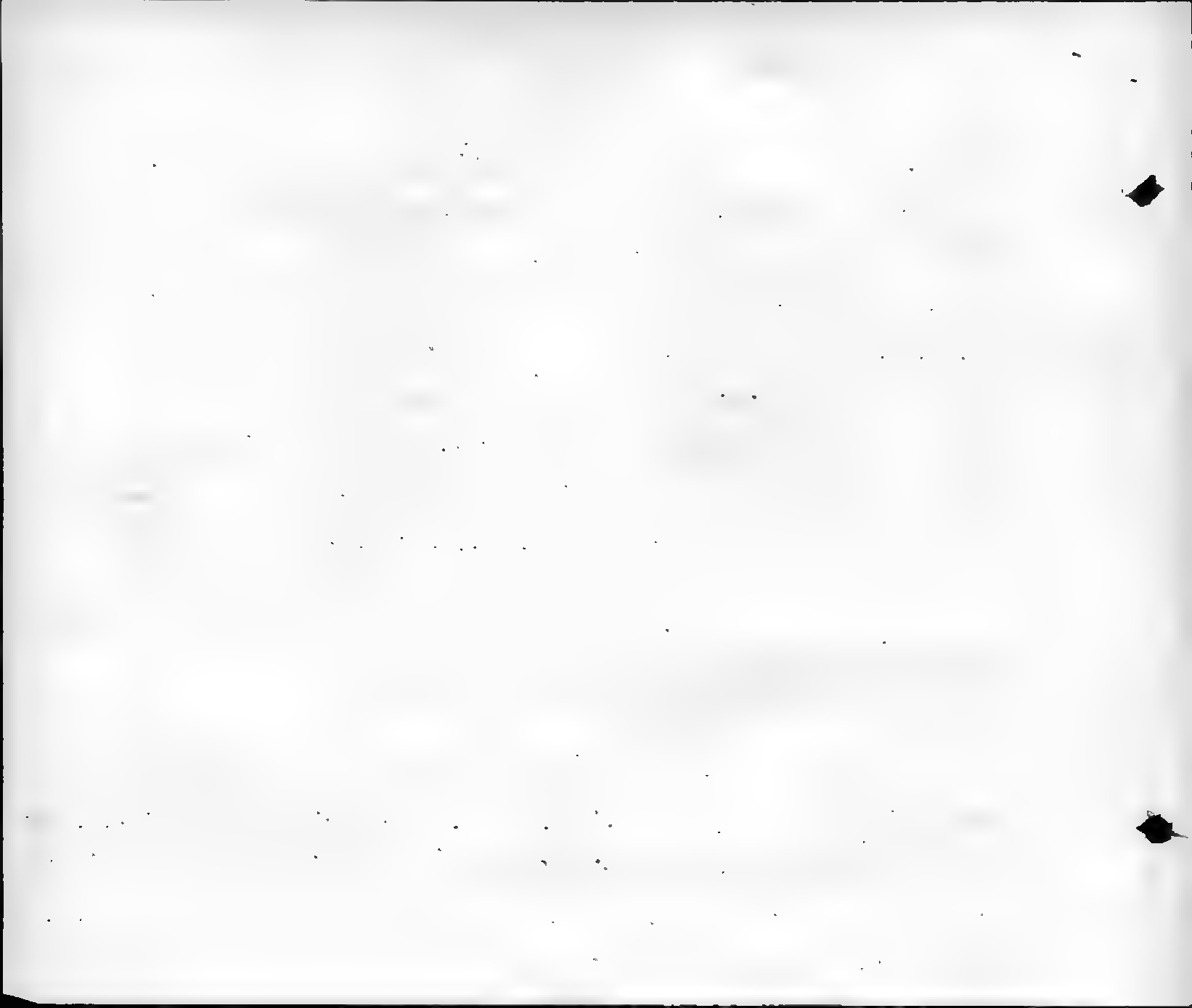
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14201

CERTIFICATE OF DEATH

Reg. Dist. No. 14162

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb since 1935	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7800 Hampden Lane</u>		e. STREET ADDRESS <u>7800 Hampden Lane</u> <u>/ Bethesda, Maryland</u>	
3. NAME OF (Type or print) First Middle Last <u>Robert H Slaughter</u>		4. DATE OF DEATH Month Day Year <u>Dec 24 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <u>2 22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Robert Slaughter</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Bannester</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Louise T. Slaughter-wife-same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary thrombosis</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerotic heart disease 2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1957</u> to <u>Dec 24 1960</u> , that I last saw the deceased alive on <u>Dec 23 1960</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>		ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		DATE SIGNED <u>Dec 24, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



Page 4 death Page 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

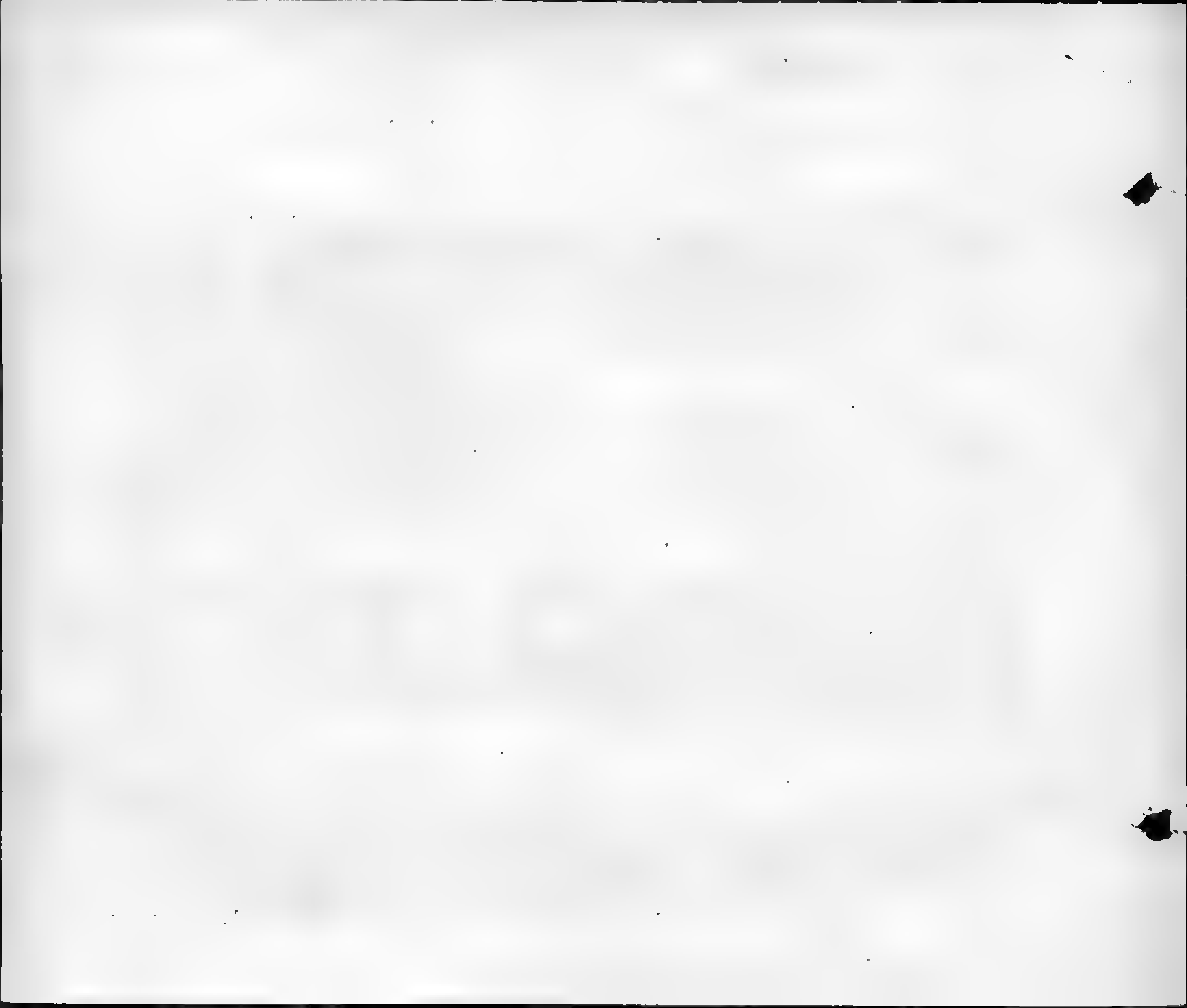
VR A15 (4)
15M 9-59

14202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14163

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Milwood Farms		d. STREET ADDRESS 4201 Warren St. N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last CHARLES LOUIS SMITH		4. DATE OF DEATH Month Day Year Dec 31 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1898
9 AGE (In years lost birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 9 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles L. Smith		14. MOTHER'S MAIDEN NAME Annie Mullens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No Yes WW 1		16. SOCIAL SECURITY NO None	
17. INFORMANT Alma G. Smith-wife-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420-1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive vascular disease.		INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR 5 YEARS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from MARCH 1960 to DEC 31, 1960 , that (I) (we) last saw the deceased alive on DEC 30, 1960 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Earl H. Mitchell		22b. DATE SIGNED 12/31/60	
22c. PHYSICIAN'S NAME (Type) EARL H. MITCHELL		22d. ADDRESS 2029 Q St. N.W. WASHINGTON DC.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR JAN 3 '61	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

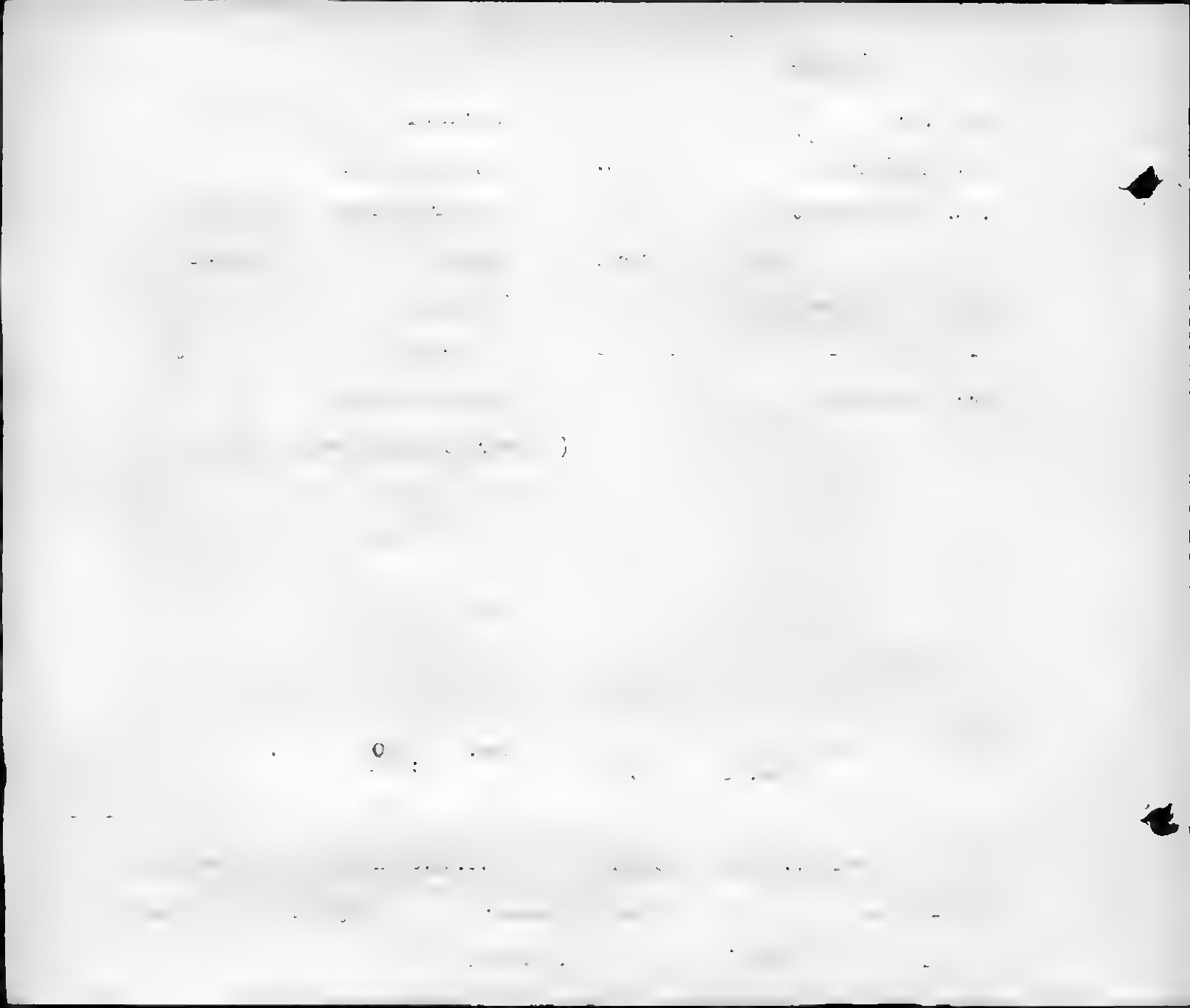
14203

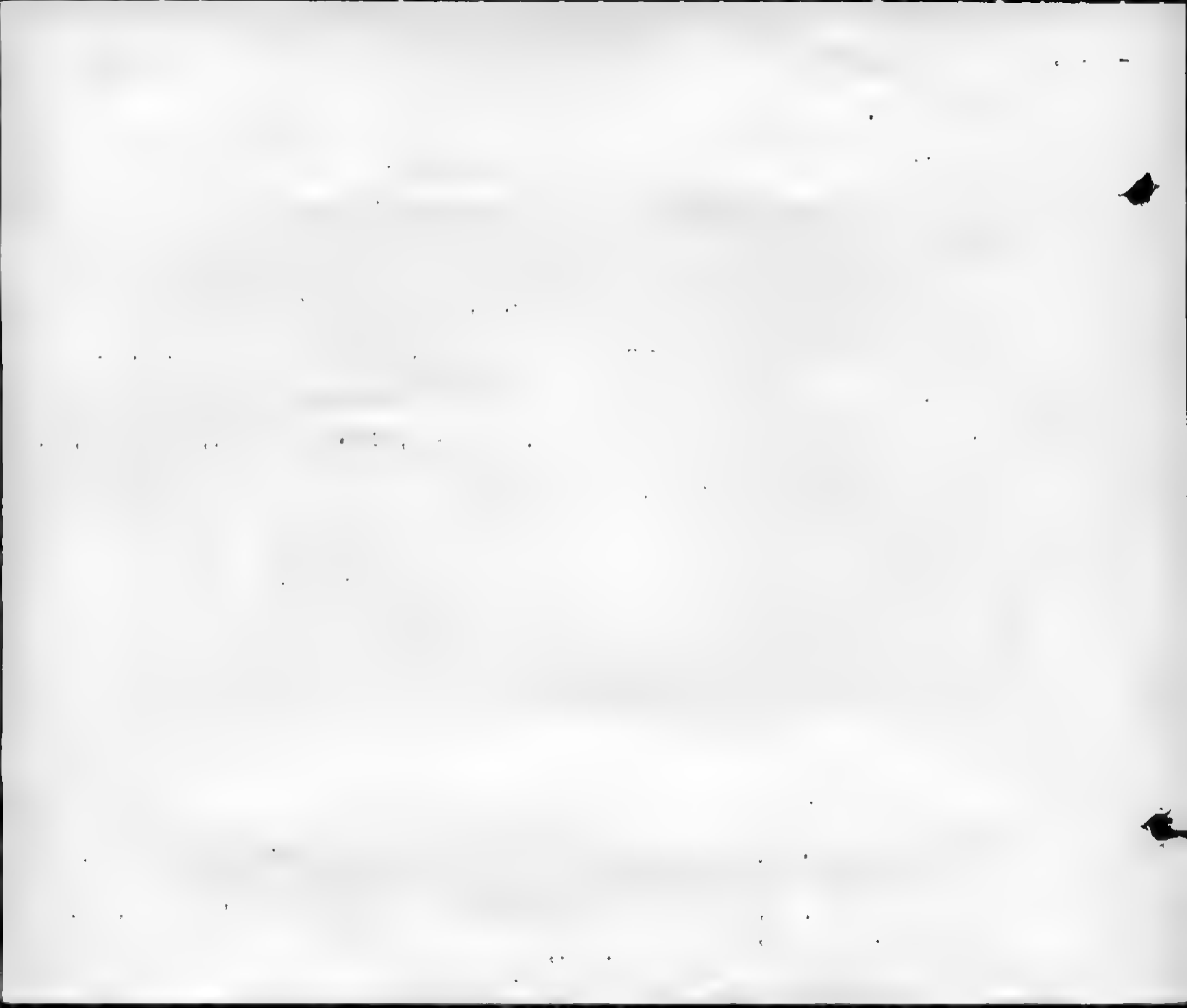
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1416a

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 40 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 68 Coral Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Jean Carol SMITH		4. DATE OF DEATH Month Day Year December 10 1960	
5 SEX Female	6 COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-30-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Larry Gene SMITH		14. MOTHER'S MAIDEN NAME Mary Lynn HEYDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Larry G. Smith, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adrenal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) meningococcal septicemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 24 HOURS			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Dec. 10 1960 to Dec. 10 1960 , that (I) last saw the deceased alive on Dec. 10 1960 , and that death occurred at 8:40AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert V. Rack		22b. DATE 12-10-60	
22c. PHYSICIAN'S NAME (Type) Robert V. RACK LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 12-11-60	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City, town, or county) (State) Hayfield Minnesota	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home		25a. REC'D BY REGISTRAR DEC 13 '60	
25b. REGISTRAR'S SIGNATURE Carlin S. Frank			

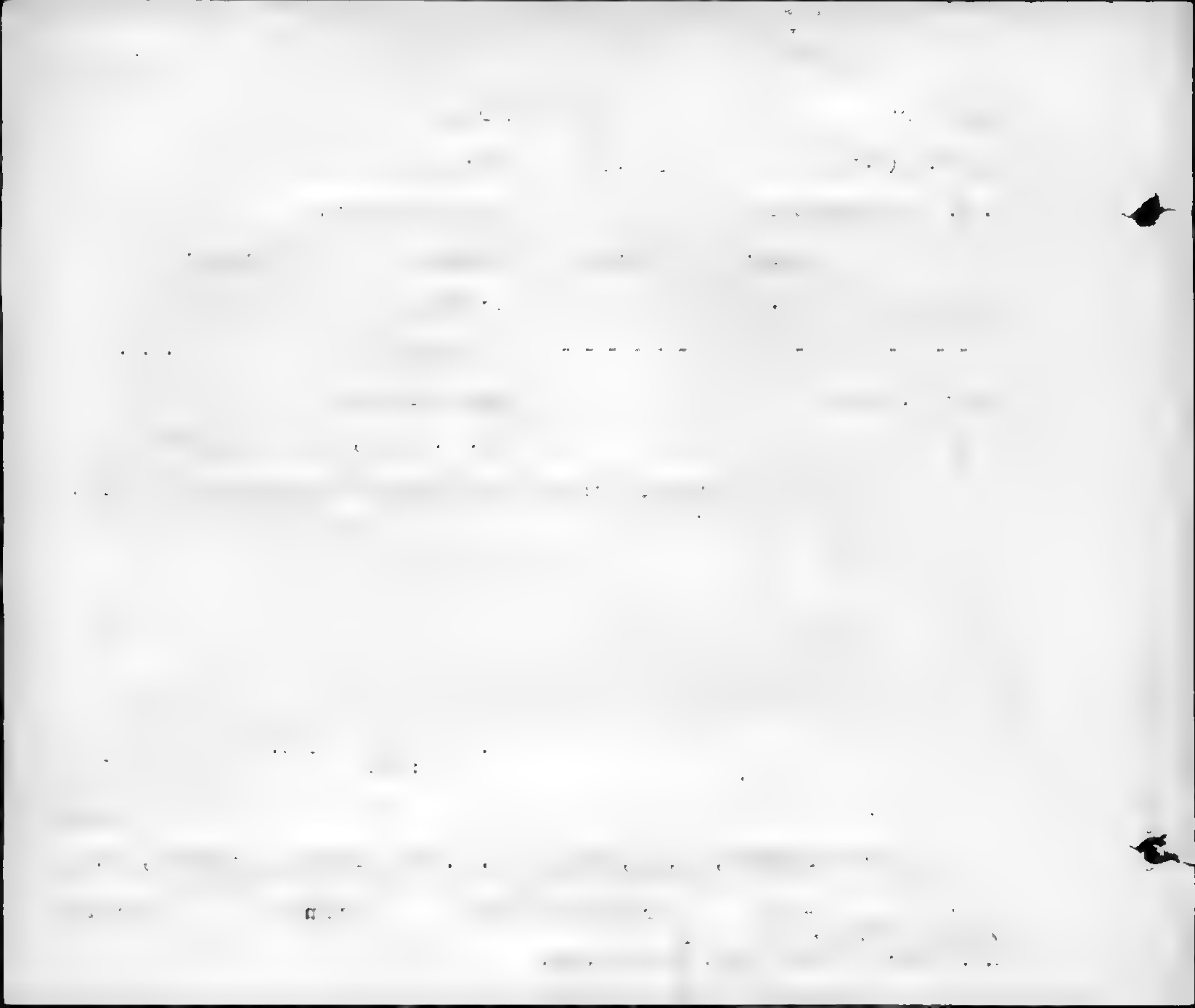
2012/12/14





14204
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
14163

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admiss.on) a. STATE Virginia b. COUNTY Hampton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampton d. STREET ADDRESS 20 Wheatland Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Robert Bruce SMITH		4. DATE OF DEATH Month Day Year December 5 19 60	
5 SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-7-48
9. AGE (in years last birthday) 12 yrs		IF UNDER 1 YEAR Months Days Hours Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Indiana		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert S. SMITH		14. MOTHER'S MAIDEN NAME Ramona DYKSTRA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. None	
17. INFORMANT (F) Robt. S. Smith, same as #2 above		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Embryonal carcinoma, left testis with widespread metastases 178x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 mos.
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Nov. 2 1960 to Dec. 5 1960 that he (we) last saw the deceased alive on Dec. 5 1960 , and that death occurred at 4:58AM M, from the causes and on the date stated above.			
22a SIGNATURE Fred W. Grello M D		22b DATE SIGNED 12-5-60	
22c PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12-8-60	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City, town, or county) (State) Arlington Virginia
24 FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS R.A. Pumphrey Funeral Home, Bethesda, Md.		25a REC'D BY REGISTRAR DATE DEC 8 '60 25b REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

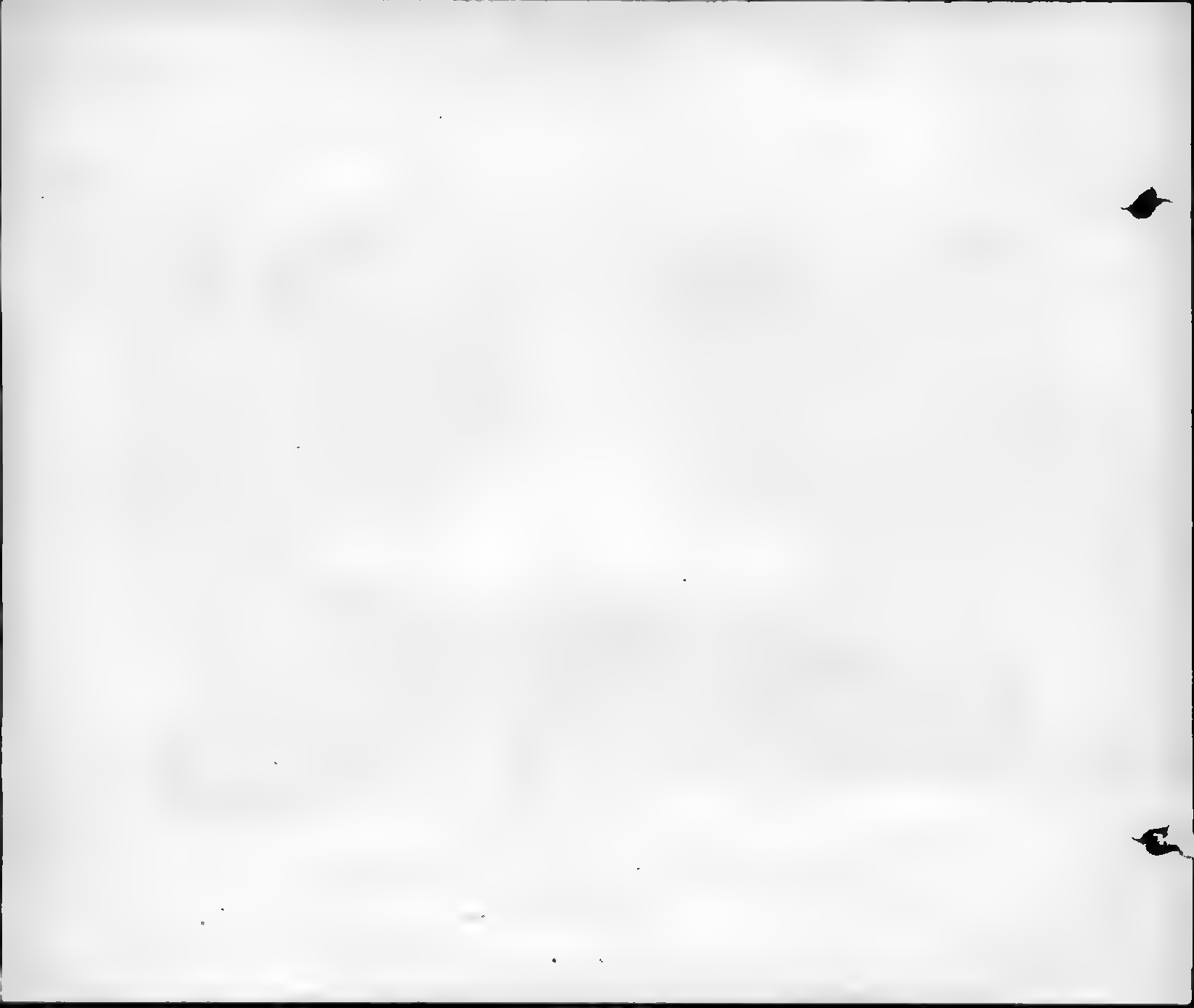
VR A15 (4)
15M 9/59

14205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14167

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle REBECCA Last SNOWDEN		4. DATE OF DEATH Month DECEMBER Day 1 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-1883
9. AGE (in years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77	11. IF UNDER 24 HRS Months 77 Days 77 Hours 77 Min 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GRAFT HOLLAND		14. MOTHER'S MAIDEN NAME ELIZABETH WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO HOSPITAL RECORDS, OLNEY, MARYLAND	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE INTO PONS 331 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL HEMORRHAGE DUE TO (c) 36 HOURS 36 HOURS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). MYOCARDIAL INFARCTION - 5 DAYS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 30, 1960 , to DEC 1, 1960 , that (I) (we) last saw the deceased alive on Nov 30, 1960 , and that death occurred at 2:40 AM from the causes and on the date stated above.			
22a. SIGNATURE C. S. Whitaker, M.D.		22b. DATE SIGNED DEC 7 '60	
22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/60	
23c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel.		23d. LOCATION (City, town, or county) (State) Highland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		25a. REC'D BY REGISTRAR DEC 7 '60	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Carl S. Frank	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 17 14-20-60 et

14168

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASHINGTON SAN. & HOSPITAL

3. NAME OF DECEASED (Type or print)

EMERY

First

Middle

Last

MARTIN SONDHEIMER

4. DATE OF DEATH

DEC.

Month

Day

Year

16 1960

5. SEX

MALE

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9-16-1898

9. AGE (In years last birthday)

62 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician Helper

10b. KIND OF BUSINESS OR INDUSTRY

Wash. Terminal

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

NATHAN SONDHEIMER

14. MOTHER'S MAIDEN NAME

Virginia Tappen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

YES

1st World War 1918-18-1925

17. INFORMANT

Mrs Alice H Sondheim

Address

1615 In Kent Act Hyattsville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH
Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Bloesch

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. BLOESCH

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

12-17-60

22a. BURIAL, CREMATION REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-20-60

22c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

22d. LOCATION (City, town, or county)

Suitland Md.

(State)

23. FUNERAL DIRECTOR

Lee Funeral Home - Wash DC

Address

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE DEC 21 '60

Charles S. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Chas. S. Krauss



MARYLAND STATE DEPARTMENT OF HEALTH

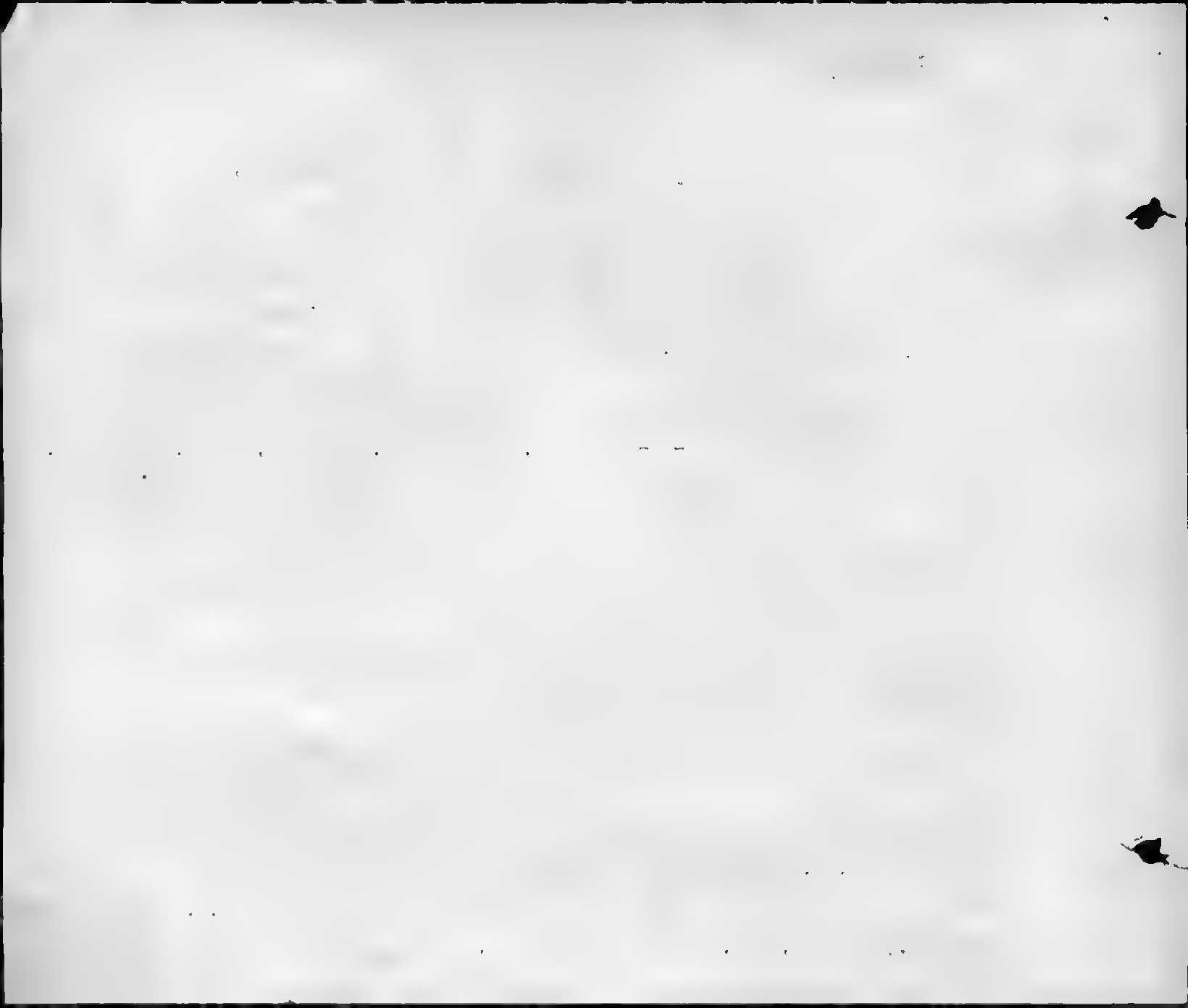
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14057

CERTIFICATE OF DEATH

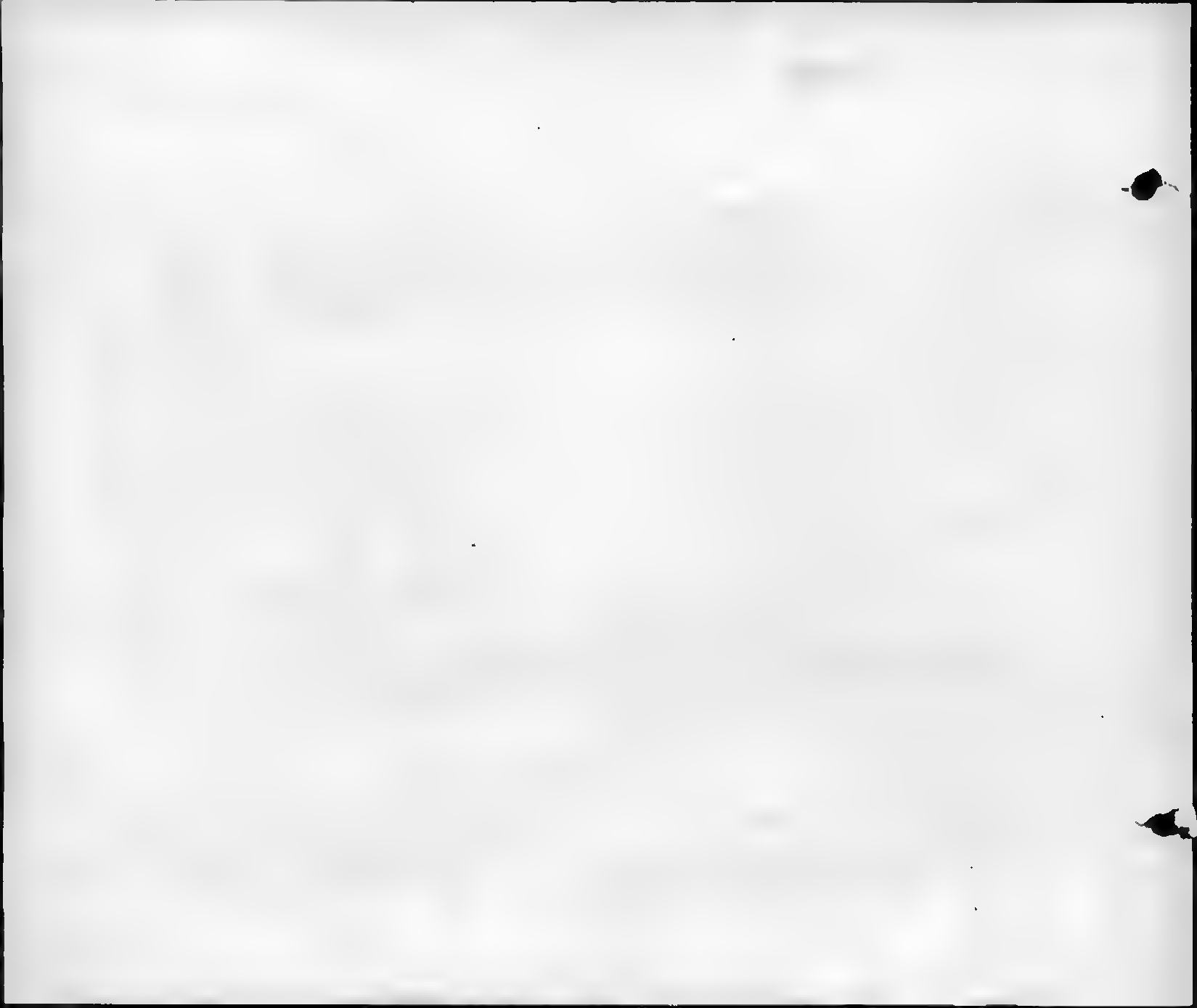
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b. <u>1 hr 20 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>277 W. Notley Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elmer Paul Steigner</u> First Middle Last		4. DATE OF DEATH <u>12-26-60</u> Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-98</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Blair High School</u>		11. BIRTHPLACE (Country & State or foreign country) <u>Chio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Theodore Steigner</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mozart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>214-03-8240</u>		17. ADDRESS <u>Mrs. Elizabeth R. Steigner, 277 W. Notley Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <u>Interval between onset and death 1 hr.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1950</u> to <u>Dec 26</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>Dec 20</u> <u>1960</u> and that death occurred at <u>11:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Wardrop MD</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>500 Pershing Drive Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF <u>12/29/60</u>	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Bumprey, Inc.</u> <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Turner</u>		25c. DATE <u>JAN 3 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. LENGTH OF STAY IN 1b <i>7 mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. BUT ON <i>Wheaton Nursing Home</i>		d. STREET ADDRESS <i>1342 Somerset Place, n.w.</i>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>-</i> Last <i>Stein</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 15-1888</i>
9. AGE (In years last birthday) <i>72 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Henry Baxd</i>	
14. MOTHER'S MAIDEN NAME <i>Rose Norvic</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Esther R. Miller</i> Address <i>1342 Somerset Place, n.w.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Cerebral arterio sclerosis</i> (b) <i>Generalized arterio-sclerosis</i> DUE TO <i>-</i> (c) <i>-</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic epilepsy</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>5/2/1960</i> to <i>12/28/1960</i> , that (I) (we) last saw the deceased alive on <i>12/27/1960</i> , and that death occurred at <i>2:35 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter K. Hingevine</i>		22b. DATE SIGNED <i>12/28/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER K HINGEVINE</i>		22d. ADDRESS <i>6300-13th St. N.W., Wash. 11, D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>12/24/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNITED HEBREW CEM.</i>	23d. LOCATION (City, town or county) (State) <i>HALETHORPE. MD.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>William J. ...</i> ADDRESS <i>4217-4th St NW</i>		25a. RECEIVED BY REGISTRAR <i>DEC 29 1960</i>	25b. REGISTRAR'S SIGNATURE <i>William J. ...</i>



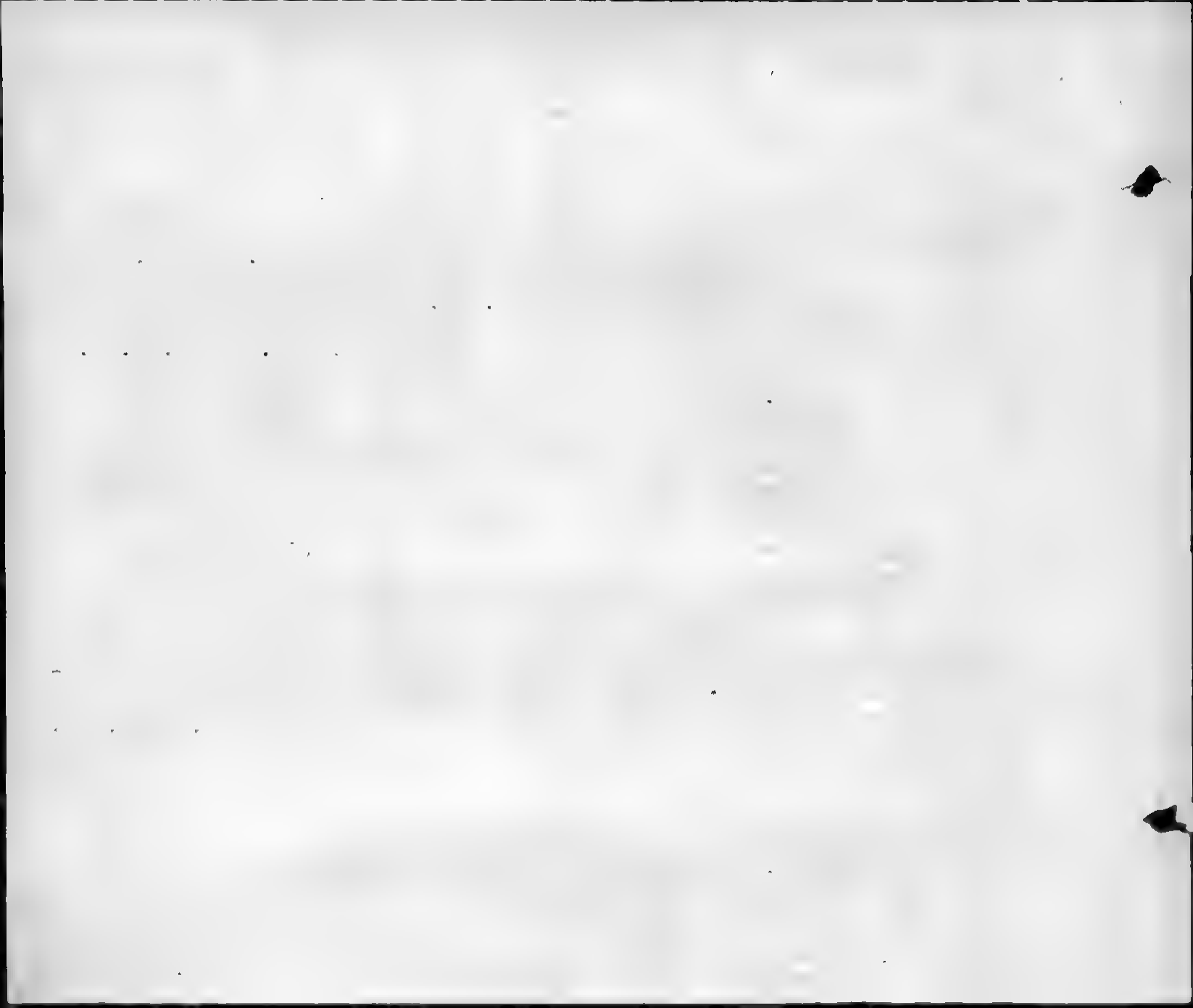
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11172

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4503 Walsh Street</u>				d. STREET ADDRESS <u>4503 XXXX Walsh Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTELLE ELIZABETH STEVENS</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> , Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 30, 1926</u>		9. AGE (In years last birthday) <u>34</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Claude T. Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Elva ? (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert Stevens-Husband-same 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> DUE TO (b) <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self with belt from shower curtain rod in bath-room.</u>					
20c. TIME OF INJURY Month, Day, Year <u>12/21 19 60</u> Hour <u>Noon</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Chevy Chase, Montg, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12/21/60</u>		
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>12/21/60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>2 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10514 Parkwood Dr</u>			d. STREET ADDRESS <u>10514 Parkwood Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles E Stowers</u>			4. DATE OF DEATH <u>Dec 11 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1920</u>		9. AGE (in years last birthday) <u>39</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Co</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Ruby Mayen</u> Address <u>Itasca 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>9210</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary tuberculosis</u> (c) <u>Aspiration of gastric contents</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Brought home at 4:15 p.m. and fell in bath. Found</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 12-11-1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Montg.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-11-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. P mphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>C. J. 8 Kline</u>

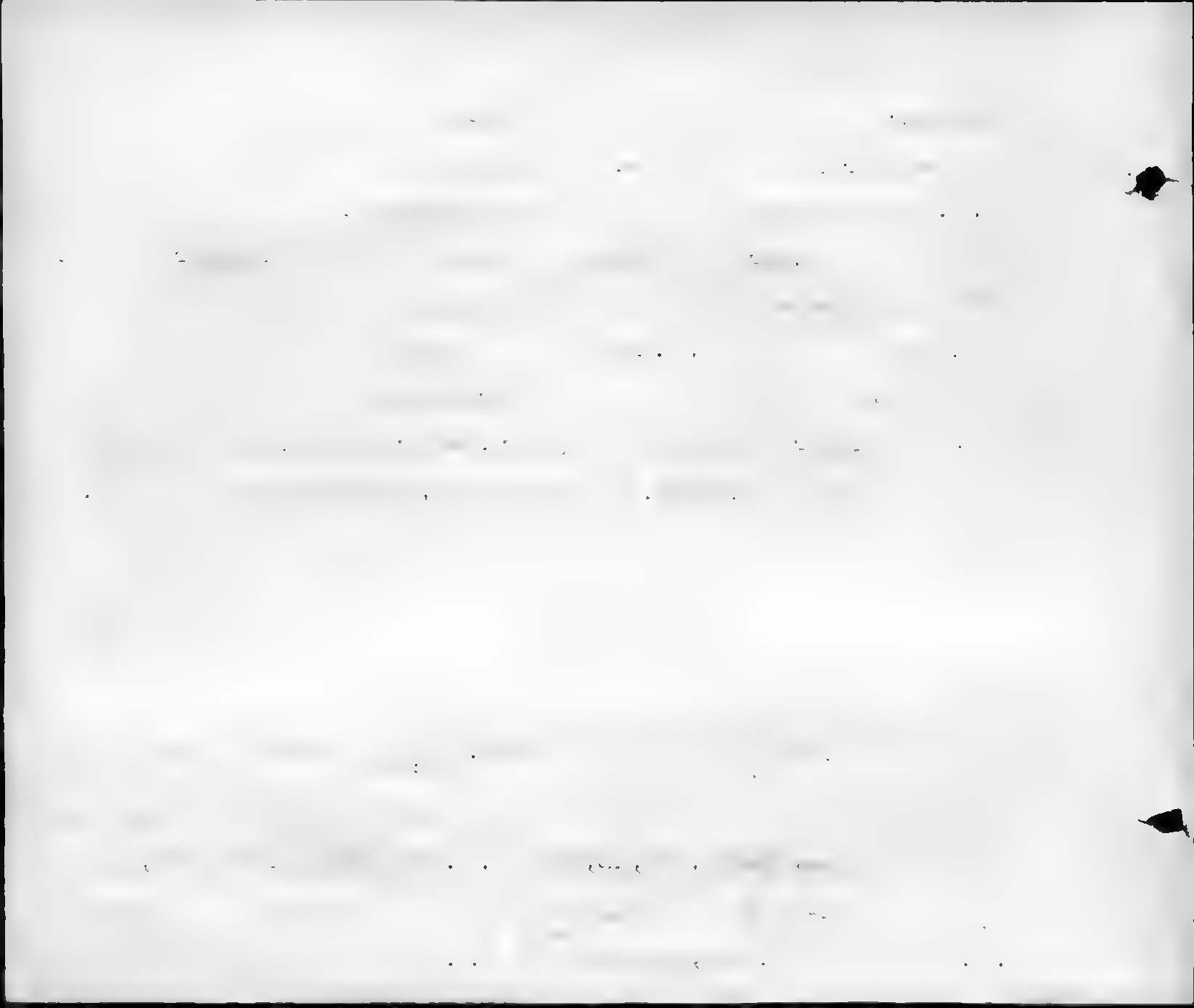


14207

14174

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 89 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Tennessee b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Memphis d. STREET ADDRESS 4002 Argonne St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Robert Gunsauls STOWELL				4. DATE OF DEATH Month Day Year December 23 1960			
5 SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-14-23	
9 AGE (In years lost birthday) 37 yrs		10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) Indiana	
13 FATHER'S NAME Jay STOWELL				14 MOTHER'S MAIDEN NAME Marie BLOMBERG			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII-Korea				16. SOCIAL SECURITY NO 561-26-0777		17. INFORMANT (W) Mrs. Margaret Stowell, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embryoma, malignant, testis, with metastasis DUE TO (b) DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (the physician) attended the deceased from Sept. 25 1960 to Dec. 23 1960 , that (I) (the physician) last saw the deceased alive on Dec. 23 1960 , and that death occurred on Dec. 23 1960 , from the causes and on the date stated above.							
22a SIGNATURE Hampton Hubbard M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 12-23-60	
22c PHYSICIAN'S NAME (Type) Hampton HUBBARD, CDR, MC, USN				22d ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12-27-60		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS WashDC		25a REC'D BY REGISTRAR DEC 29 '60	
25b REGISTRAR'S SIGNATURE Arthur S. Howard							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN (b) 6 hours		2. USUAL RESIDENCE (Where deceased lived, if institution, residence only) STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shawel		d. STREET ADDRESS 505 Cooks Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Adelle Talley		4. DATE OF DEATH December 26 1960		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1927	
9. AGE (In years last birthday) 33 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME David Jackson		14. MOTHER'S MAIDEN NAME Louise Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no.		16. SOCIAL SECURITY NO. no.		17. INFORMANT Washington Sanitarium - Hospital Records.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Brosch		EXAMINER'S NAME (Type) FRANK J. Brosch		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/60		22c. NAME OF CEMETERY OR CREMATORY Good Hope.		22d. LOCATION (City, town, or country) (State) Colesville, Md.	
23. FUNERAL DIRECTOR Robert K. Suroden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-26-60	
				24c. (City or town)		24d. (County)		24e. (State)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14436

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Pr. George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 8336-12th Ave.

3. NAME OF DECEASED (Type or print) Mionetta Tang
First Last
4. DATE OF DEATH Month 12 Day 9 Year 1960

5. SEX F 6. COLOR OR RACE Chinese 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH July 23-16
9. AGE (In years) (If UNDER 1 YEAR: Months Days Hours) (If UNDER 24 HRS: Months Days Hours) 44 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) China 12. CITIZEN OF WHAT COUNTRY? China

13. FATHER'S NAME Chum Hsiu Pe 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. No 17. INFORMANT Hosp Record Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Barbiturate poisoning
970.2 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Reported to have taken an overdose?

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Brosch M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK J. Brosch ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 12-9-60
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

22a. BURIAL (CREMATION) REMOVAL (Specify) Cremation 22b. DATE THEREOF Dec 14, 1960 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill 22d. LOCATION (City, town, or country) (State) Smithland, Md.

23. FUNERAL DIRECTOR W.W. Taltavull ADDRESS 3603 14th St NW 24a. REC'D BY REG. STRAR DEC 15 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14177

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN b. 2 yrs. 4 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CONGRESSIONAL MANOR SANITARIUM		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8720 COLESVILLE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY CHARLOTTE TAYLOR		4. DATE OF DEATH Month DECEMBER Day 5 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER (retired)		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN REAGAN ROCHE		14. MOTHER'S MAIDEN NAME NANCY KRAM GRAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. OLIVE FLOWTON, 8720 COLESVILLE RD., SS., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO (b) WOUND INFECTION DUE TO (c) FRACTURED RIGHT HIP PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 22 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. FELL ON FLOOR AT SANITARIUM		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL ON FLOOR AT SANITARIUM	
20c. TIME OF INJURY Month, Day, Year 9:50 a.m. NOV. 12 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SANITARIUM		20f. City or town (County) (State) BETHESDA, MONTGOMERY, MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) FRANK J. BROSCHART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEC. 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/60	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or country) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. <i>Raymond A. Ziska</i>		24a. REC'D BY REGISTRAR DEC 12 1960 24b. REGISTRAR'S SIGNATURE <i>Charles E. Henshaw</i>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **14178**

14083

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>17 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg County Jail</u>				d. STREET ADDRESS <u>240 N. Washington St</u>			
3. NAME OF DECEASED (Type or print) <u>Davis Thomas</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-21-1919</u>	
9. AGE (in years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Police Record</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fat Embolism</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatic Fatty Metamorphosis</u></p> <p>(c) <u>Chronic & Acute Alcoholism</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p> <p><u>Unknown</u></p> <p><u>Unknown</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Chronic Subdural Hematoma</u></p>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>County Home Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shawder</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. S. ...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14209

CERTIFICATE OF DEATH

Reg. Dist. No. 14179

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>		d. STREET ADDRESS <u>1319 Longfellow St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest D. Thorne</u>		4. DATE OF DEATH Month Day Year <u>12 5 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1879</u>
9. AGE (In years last birthday) yrs <u>81</u>		10. IF UNDER 1 YEAR: Months Days Hours Min <u>81</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Business Friendly, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Albert Thorne</u>		14. MOTHER'S MAIDEN NAME <u>Ida E. Whitmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>579-28-7937</u>	
17. INFORMANT <u>LOUIS P. ALLWINE</u>		<u>11411 Rockville Pike Rockville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. _____ 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Dec 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>60</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8601 old Georgetown Rd</u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill MD</u>		<u>Bethesda 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-8-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		24a. REC'D BY REGISTRAR <u>DNFC B '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

FOR THE BOARD OF DIRECTORS
OF THE COMPANY

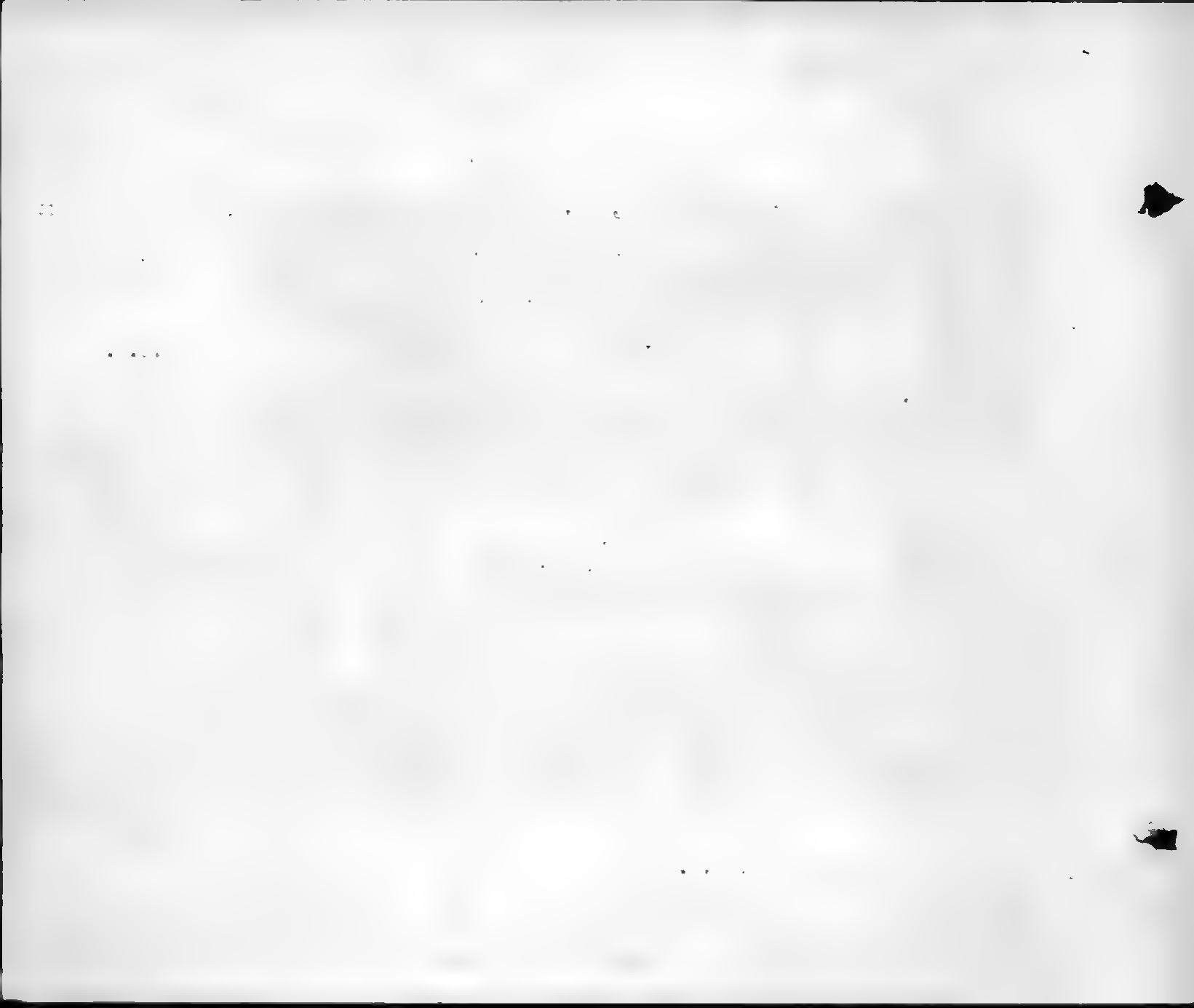
MC

CERTIFICATE OF DEATH

Reg. Dist. No. 14180

14210

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 167 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY Roanoke c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke d. STREET ADDRESS 2215 South Jefferson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Caroline Last Thornton				4. DATE OF DEATH Month December Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 October 1934	
9. AGE (In years last birthday) 26		10. IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. 26		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Edward G. Umberger				14. MOTHER'S MAIDEN NAME Fannie Radcliff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia and Hemothorax DUE TO (b) Pancytopenia DUE TO Choriocarcinoma with pulmonary, pelvic, vaginal, and bladder metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 173X							
INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 10 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 22, 1960 to December 6, 1960 , that I last saw the deceased alive on December 6, 1960 , and that death occurred at 7:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 12/7/60							
ACTUAL SIGNATURE Leo Stolbach, M.D.				PHYSICIAN'S NAME (Type) Leo Stolbach, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-7-60				22b. DATE THEREOF 12-7-60			
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery				22d. LOCATION (City, town, or county) (State) Roanoke, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				24. REC'D BY REGISTRAR DEC 8 '60			
ADDRESS Bethesda, Maryland				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 15 (4)
15M 9/59

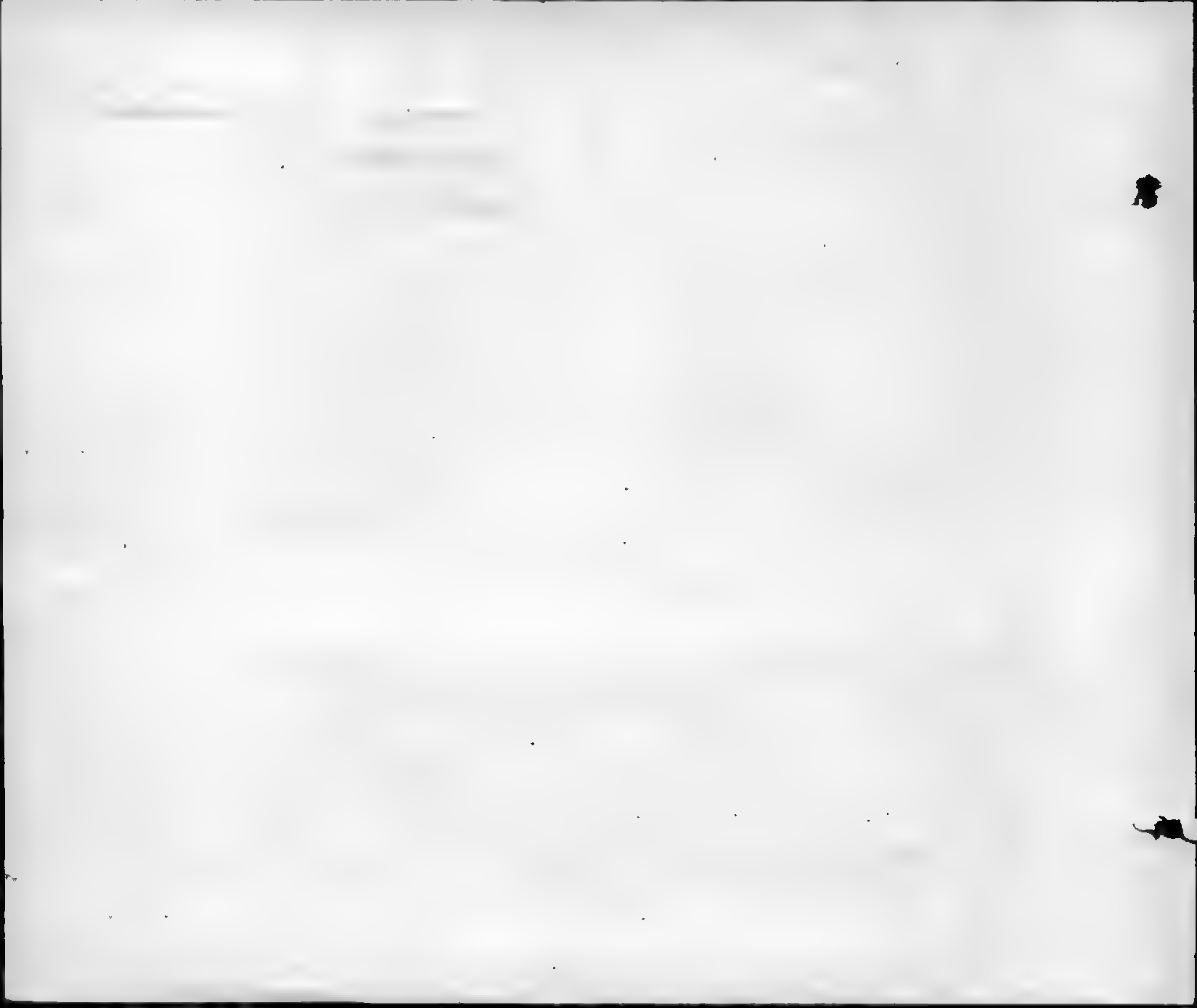
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14078

14181

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington M.D.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Garden Sanitarium				e. STREET ADDRESS 5118 9th Street N.W.			
3. NAME OF DECEASED (Type or print) First JOHN Middle TOMASULO Last TOMASULO				4. DATE OF DEATH Month 12 Day 27 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/90	9. AGE (in years last birthday) 70 yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours M n.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Tomasulo				14. MOTHER'S MAIDEN NAME Marguerite Girardi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?		17. INFORMANT Vincent J. Tomasulo 1708 Donald Place Silver Spring, Md.			
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 3 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/30 19 58 to 3/27 19 60 that (I) (we) last saw the deceased alive on 3/27 19 60 and that death occurred 4/5/60 from the causes and on the date stated above							
22a. SIGNATURE Harold S. ...				22b. ADDRESS 1352 UNIVERSITY AVE			
22c. PHYSICIAN'S NAME (Type) HAROLD S. ...				22d. ADDRESS 1352 UNIVERSITY AVE			
23a. BURIAL, CREMATION, REMOVA. (Specify) burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges, 1	
24. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co				25a. REC'D BY REGISTRAR 2901-14 St. M.W.		25b. REGISTRAR'S SIGNATURE DEC 29 '60	

WASH. D.C.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

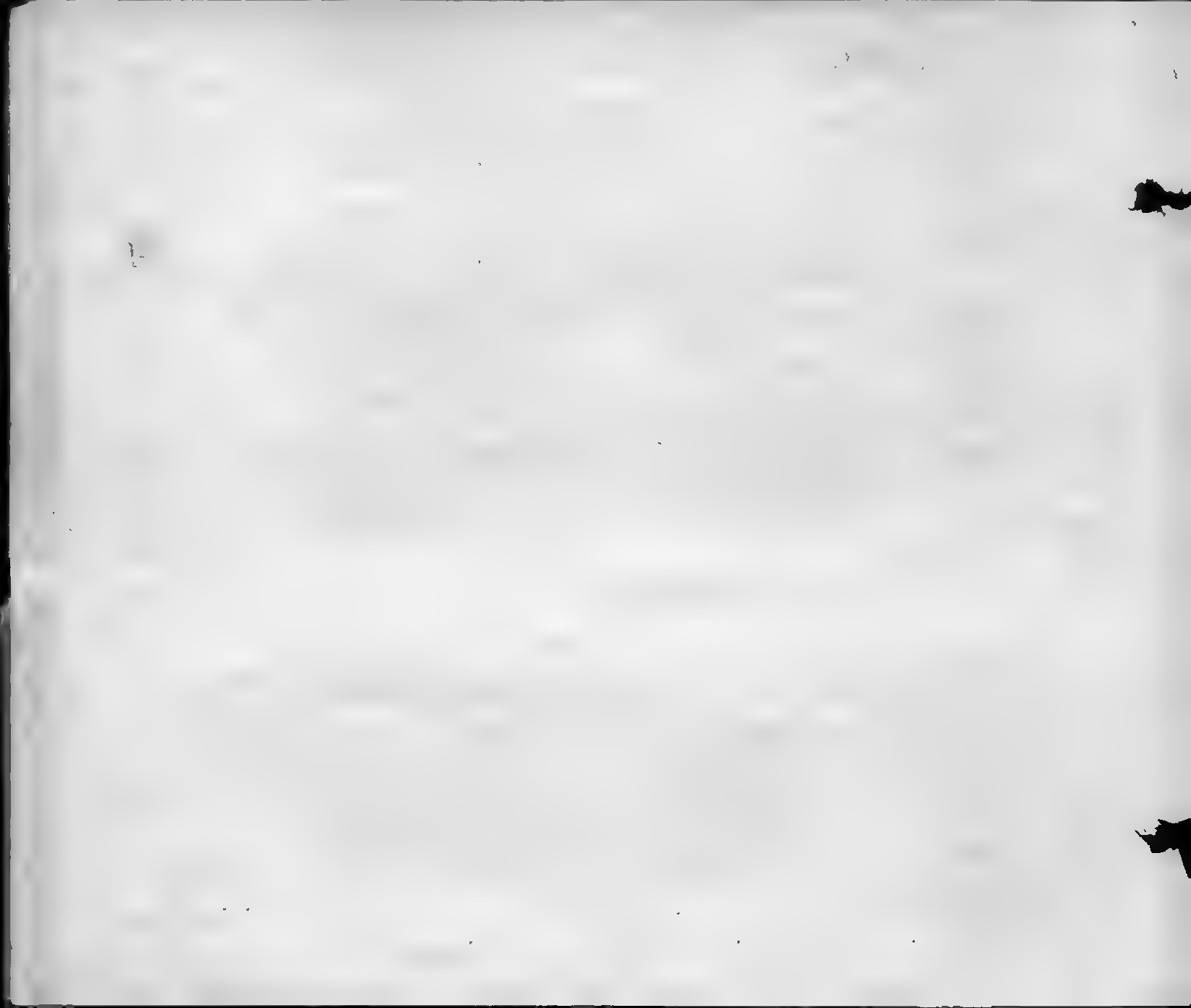
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14182

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Kensington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN b. 3 hours		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hospital			e. STREET ADDRESS 3118 Ferndale Street		
3. NAME OF DECEASED (Type or print) Joseph James Walder			4. DATE OF DEATH December 24 1960		
5. SEX male			6. DATE OF BIRTH April 10, 1922		
7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. AGE (In years last birthday) 38		
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit Manager			10. BIRTHPLACE (State or foreign country) New York		
11. FATHER'S NAME Louis Walder			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. MOTHER'S MAIDEN NAME Mary King			14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		
15. SOCIAL SECURITY NO. 1942-1946 080-14-4076			16. INFORMANT Mrs. Elizabeth L. Walder		
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACERATIONS, MULTIPLE LIVER & SPLEEN WITH HEMORRHAGE, FRACTURES, MULTIPLE, RIBS, & LACERATIONS, LEFT LUNG, WITH HEMORRHAGE Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last DUE TO AUTO ACCIDENT			18. INTERVAL BETWEEN ONSET AND DEATH 3 hrs		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.					
19. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was driven from westward in truck on collision		
21. TIME OF INJURY Hour 10:20 p.m. Month, Day, Year 12-23-60			22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Wheaton Monty Md		
23. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
25. ACTUAL SIGNATURE Frank J. Broschaw			26. DATE SIGNED 12-24-60		
27. EXAMINER'S NAME (Type) FRANK J. BROSCAW			28. ADDRESS (Street, city, town, or county) SILVER SPRING, MD.		
29. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT			30. DATE THEREOF 12/28/60		
31. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY			32. LOCATION (City, town, or country) WASHINGTON, D.C.		
33. FUNERAL DIRECTOR Edmond E. Glick			34. REC'D BY REG STRAR DEC 29 '60		
35. REGISTRAR'S SIGNATURE Arthur S. Kline					

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

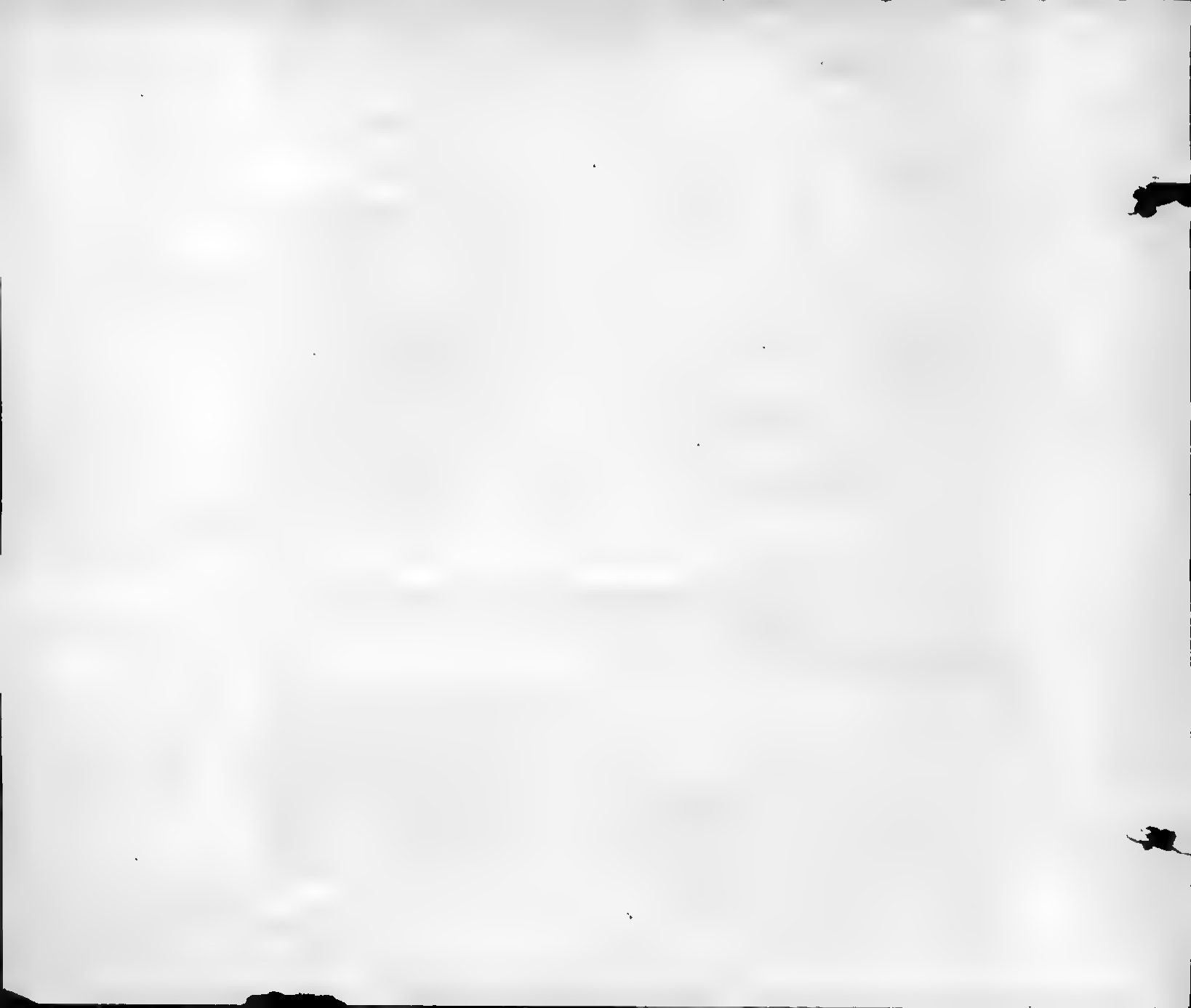
CERTIFICATE OF DEATH

14061

14183

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shoreline Hospital</u>				d. STREET ADDRESS <u>11216 MARKWOOD DR.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Lewis SHAKER</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1960</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-09</u>		9. AGE (In years last birthday) <u>51</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Rep. Dr. Chem. Co. New York City</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Historic of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel SHAKER</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth SHAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-07-0160</u>		17. INFORMANT <u>St. Mary's Record</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A. S. Ht Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1958</u> to <u>Dec 13 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 13 1960</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Leon L. Gallin</u>				22b. DATE SIGNED <u>Dec 13 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>Leon L. Gallin MD</u>	
22d. ADDRESS <u>University Heights Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-15-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEM. GARDENS</u>		23d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loebberg Funeral Home 4217-9th St NW</u>				25a. REC'D BY REGISTRAR <u>DEC 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for yourself. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14211 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
14184									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney					c. LENGTH OF STAY IN TB DOA				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. General Hosp.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg Box 294				
d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) George Washington					4. DATE OF DEATH Dec. 31, 1960				
5. SEX male 6. COLOR OR RACE col.					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2/2/24				
9. AGE (In years, test birthday) 36 yrs.					10. AGE (In years, test birthday) 36 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer					11. BIRTHPLACE (State or foreign country) USA				
10b. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Henruetta Neal					14. MOTHER'S MAIDEN NAME Paul Turner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT Police Record					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of multiple lung abscesses (lt.)									
493X DUE TO (b) pneumonia									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day Year 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED 12/31/60									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 11-3-61									
22c. NAME OF CEMETERY OR CREMATORY Brownstown									
22d. LOCATION (City, town, or country) (State) Germantown, Md.									
23. FUNERAL DIRECTOR Robert L. Snowden									
Address Rockville, Md.									
24a. REC'D BY REGISTRAR JAN 9 '61									
24b. REGISTRAR'S SIGNATURE Robert L. Snowden									

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Frank J. Broschart

Frank J. Broschart



14079

14185

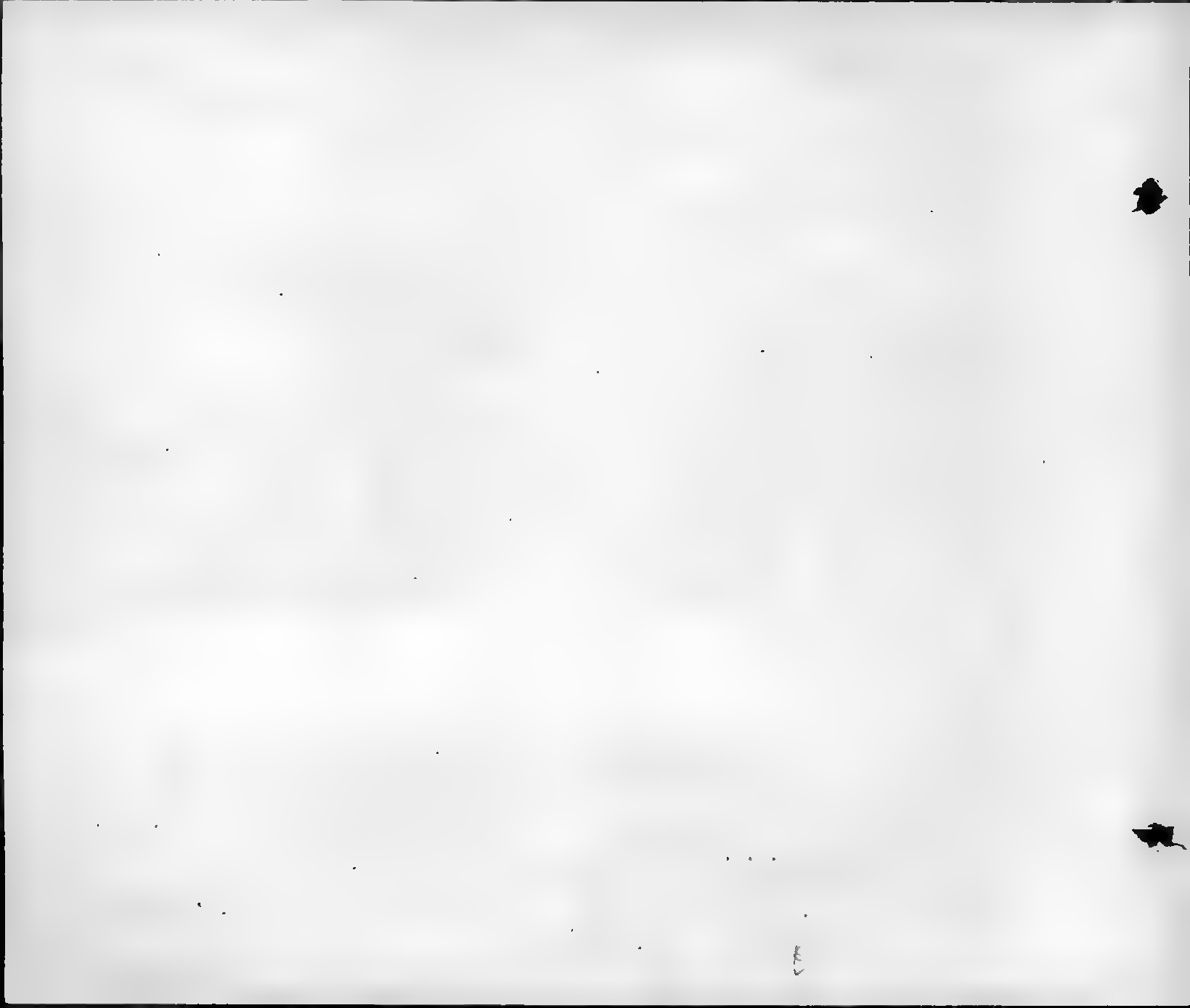
1

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
c. LENGTH OF STAY IN 1b <i>2 days</i>				d. STREET ADDRESS <i>1212 Highwood Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens San.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Edward Webb</i>				4. DATE OF DEATH Month Day Year <i>12 - 27 - 1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 3 '01</i>		9. AGE (In years last birthday) <i>59 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <i>8 24</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>special police agent - Govt.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Akron Ohio</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>William E. Webb</i>				14. MOTHER'S MAIDEN NAME <i>Andrews</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>1919-1923</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs. Myrtle Webb, 1212 Highwood Road, Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer - Bronchus - 3 1/2 years</i> DUE TO <i>metastases to mediastinum</i> (b) <i>Congestive Heart Failure</i> DUE TO <i>(terminal)</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 15 1960</i> to <i>Dec 27, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec 27 1960</i> , and that death occurred at <i>6 A</i> M. from the causes and on the date stated above							
22a. SIGNATURE <i>SAM ALLEN, M.D.</i>				22b. ADDRESS <i>Kensington, Maryland</i>		22c. DATE SIGNED <i>DEC. 27th, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>SAM ALLEN, M.D. 10407</i>							
23a. BURIAL, CREMATION, or other disposal (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>DEC. 30, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WASHINGTON NATIONAL CEMETERY</i>		23d. LOCATION (City, town or county) (State) <i>SUITLAND, MARYLAND</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Martin W. Hyson, Co.</i>				ADDRESS <i>WASH. D.C. 1300-N Street N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 29</i>	
				25b. REGISTRAR'S SIGNATURE			

W. H. H. H.





14212

CERTIFICATE OF DEATH

Reg. Dist. No.

14187

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9940 Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>I.</u> Last <u>Windsor</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1891</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Urbana, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry W. Windsor</u>				14. MOTHER'S MAIDEN NAME <u>Catherine F. Cain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WW # 1 577-24-0666</u>		INFORMANT <u>Mrs Lucinda Windsor</u>		Address <u>Item 8</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u> 1 <u>63X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <u> </u> Not while <input type="checkbox"/> of work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>59</u> , to <u>DEC 29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DEC 28</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MAIN ST.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>G. F. Magadors, M.D.</u>		M.D. <u>DAMASCUS, MD.</u>					
PHYSICIAN'S NAME (Type) <u>G. F. MAGADORS, M.D.</u>		<u>DAMASCUS, MD.</u>					
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 3, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. W. Johnson</u>		ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carling L. Kross</u>	



142
FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14188

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNA ARUNDEL			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY in 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,704 MALONE STREET				d. STREET ADDRESS WOODLAND BEACH			
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR MELVILLE WOLFE				4. DATE OF DEATH Month Day Year DEC. 28 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/92	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian, retired				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Prisons U. S. Gov't.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN L. WOLFE				14. MOTHER'S MAIDEN NAME ANNA L. GIBBONS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. yes			
17. INFORMANT Mr. John A. Wolfe, 10,704 Malone St. Silver Spring, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>History of hypertension</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/31/60		22c. NAME OF CEMETERY OR CREMATORY Oakfield Chapel Cemetery	
22d. LOCATION (City, town, or country) (State) Hughesville, Maryland							
23. FUNERAL DIRECTOR WILLIAM E. BUMBIREY, INC. <i>Raymond A. Ziska</i>				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 4 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

CERTIFICATE OF DEATH

Reg. Dist. No. 14189

14213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ironton	
		d. STREET ADDRESS 1628 1/2 South 3rd Street	
3. NAME OF DECEASED (Type or print) First Charles Middle Franklyn Last Zeek		4. DATE OF DEATH Month December Day 2 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1 1922
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min.	11. IF UNDER 24 HRS. Months 38 Days 38 Hours 38 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Metal Work	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles D. Zeek		14. MOTHER'S MAIDEN NAME Myrtle Bryant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 233-30-2865	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Insufficiency, post operative DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 19 60 to December 2, 19 60 that I last saw the deceased alive on December 2, 19 60 and that death occurred at 11:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William C. Awe		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/3/60	
PHYSICIAN'S NAME (Type) William C. Awe M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 12-3-60		22b. DATE THEREOF 12-3-60	
22c. NAME OF CEMETERY OR CREMATORY Zoar Cemetery		22d. LOCATION (City, town, or county) (State) Lawrence County, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DEC 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kins	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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